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the Wisconsin Medical Journal

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THE STATE MEDICAL SOCIETY OF WISCONSIN

A Monthly Journal of Medicine and Surgery

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VOLUME LXII
JANUARY 1963—DECEMBER 1963

the Wisconsin Medical Journal

ESTABLISHED 1903

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the Wisconsin Medical Journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

Vol. 62, No. 1—JANUARY 1963

STATE MEDICAL SOCIETY OF WISCONSIN — MEDICINA NUSQUAM NON EST

Contents

SPECIAL FEATURES

	Page
Physician and Hospital Records Retention and Inspection; An Interpretation of Chapter 301; Laws of 1959	3
County Medical Society Sponsorship of Health Programs	8
Medical Staff Rules and Regulations as to Sterilizations	9
Physicians' Guidelines for Delegation of Duties and Functions to Nurses	11
Legal Limitations on Treating the Sick in Wisconsin; An Interpretation of The Medical Practice Act	13
Abortion; Protect Yourself	26
The Right to Use the Title "Doctor" in Wisconsin	27
University Hospitals Guide for Referring Physicians	29
Problems of a Physician's Widow	36
Medical Loans and Scholarships Available to Wisconsin Medical Students	37
How to Complete a Death Certificate	42
Drugs Subject to Federal Narcotic Laws	43
Professional Liability	48
Locum Tenens	50
Poison Information Centers	51
Responsibility of the Physician Conducting Pre-Employment Examinations	52
Your Deadlines and Other "Musts"	53
How Long Should You Keep Your Professional Case Records and X-rays?	55
Charter Law of Medical Societies in Wisconsin	56
Constitution and Bylaws of the State Medical Society of Wisconsin	57
Principles of Medical Ethics of the American Medical Association	65
Services to Members	66
List of Members, State Medical Society of Wisconsin	67
Map Indicating Location of Councilor Districts	80
SMS Officers and Councilors 1962–1963	81
SMS Standing Committees 1962–1963	82
Officers of Sections of SMS	84
SMS Council Committees 1962–1963	85
Recipients of the Presidential Citation	86
Past Presidents of the State Medical Society	87
List of State and County Officers and Scheduled Meetings of County Medical Societies	88
Officers of State Boards and Commissions	90
List of Officers and Board of Trustees of the Charitable, Educational and Scientific Foundation of SMS	94
Medicolegal Information	95
Schedule of Programs of the "March of Medicine"	96
1963 SMS Annual Meeting—Preliminary Plans	16*
List of 1962 Advertisers	56*
Principles of Advertising	57*
Index	61*

EDITORIALS

President's Page: The Shrine Burn Center for Children, by N. A. Hill, M.D., Madison	97
Our Sixtieth	98
Parsimony in Dairyland	100

REGULAR FEATURES

Preparation of Manuscripts	6*
Medical Forum	101
Society Records	35*
Calendar of Meetings	37*
Medical Meetings—Postgraduate Courses	37*
Facts About Wisconsin Physicians Service	46*
Physicians' Exchange	58*
Index to Advertisers	62*

* Advertising section.

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Journal
Established 1903

Annual Subscription_____$6.00
Single Copy_____ 1.00
Previous Years'_____ 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Pork Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 303 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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PREPARATION OF MANUSCRIPTS FOR WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor, Wisconsin Medical Journal, Box 1109, Madison 1, Wisconsin.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11, with one-inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Index Medicus* published monthly by the National Library of Medicine, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I know about it,
Wisconsin Med. J. 54:717–719 (Dec.) 1954.

And, include only those references specifically referred to in the text.

Reprints: An order slip for reprints with a table covering cost will be sent with the galley proof to each contributor.

Illustrations: Four illustrations per article are allowed without cost to the author. Beyond this number the author must pay the actual cost of illustrations. Place the name of the author on the back of each illustration, table, etc. Submit clear and distinct 3 by 5 glossy photographs. Make drawings in black ink on white paper. Attach a slip of paper to the bottom of the illustration with the author's name, identification of article, and appropriate legend. Photographs and drawings will be returned if so requested.

Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

CHECK LIST FOR AUTHORS SUBMITTING MANUSCRIPTS

- ☐ Address the manuscript to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison 1, Wisconsin.
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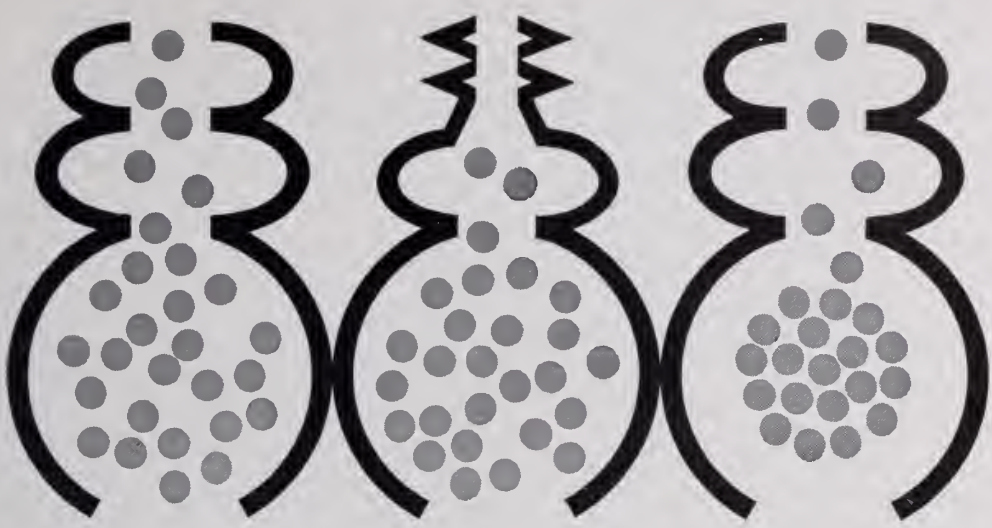

lowers motility | relieves cramping | stops diarrhea

LOMOTIL® Antidiarrheal tablets and liquid

(brand of diphenoxylate hydrochloride with atropine sulfate)

Traditionally the most effective means of slowing excess intestinal motility in diarrhea and so of relieving the disorder have been the opium derivatives. Now Lomotil makes available an antidiarrheal agent[1] of greater therapeutic efficiency than morphine.

By controlling hypermotility, the basic mechanical dysfunction of diarrhea, Lomotil reduces the frequency and fluidity of stools, diminishes cramping and controls diarrhea in many patients in whom other drugs have proved inadequate.

In a recent clinical report Cayer and Sohmer[2] state: "The alleviation of symptoms [with Lomotil] was usually prompt, occurring within 24 to 72 hours even in the long-standing chronic cases. . . . A surprisingly satisfactory response was obtained in 75 per cent of the patients with regional enteritis and in 63 per cent of those with ulcerative colitis, all of whom had failed to respond to other measures."

The high therapeutic efficiency of Lomotil, its safety, convenience and economy may be used to advantage in acute or chronic diarrhea.

Dosage: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily. Maintenance dosage may be as low as two tablets daily.

Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

Note: Lomotil is an exempt preparation under Federal narcotic statutes.

Detailed information and directions for use in children and adults are available in Physicians' Product Brochure No. 81. G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholino-Butyrylpyrrolidine and Related Amides. 1. Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. 9:381-400 (June) 1957.
2. Cayer, D., and Sohmer, M. F.: Long-Term Clinical Studies with a New Constipating Drug, Diphenoxylate Hydrochloride, N. Carolina Med. J. 22.600-604 (Dec.) 1961.

G. D. SEARLE & CO. *Research in the Service of Medicine*

1963 ANNUAL MEETING

Something Important for Every Physician

Working closely with the various specialty societies and the Wisconsin Academy of General Practice, the Commission on Scientific Medicine has prepared an outstanding program for the Annual Meeting in Milwaukee, May 6–7–8–9. To give you an opportunity of planning your attendance, the outline of the Scientific Program is included in the January and February issues of the JOURNAL. The March issue will include full details, and *around the latter part of March a special announcement on the noon scientific luncheons will be sent you.*

PLAN NOW TO ATTEND, AND MARK YOUR CALENDAR FOR THESE DATES

MONDAY, MAY 6; TUESDAY, MAY 7; AND WEDNESDAY, MAY 8

House of Delegates sessions

TUESDAY, MAY 7

1. Current Concepts of Arteriosclerosis and Hypertension

A. CURRENT PATHOPHYSIOLOGICAL CONCEPTS OF ARTERIOSCLEROSIS AND HYPERTENSION: Paul Kimmelsteil, M. D., Milwaukee

B. PITFALLS IN DRUG THERAPY: Charles W. Crumpton, M. D., Madison

C. THE PRESENT SURGICAL APPROACH: Ormand C. Julian, M. D., Chicago

2. Diabetes and Smoking as Special Problems in the Aged

A. MANAGEMENT OF THE ELDERLY DIABETIC: George Hamwi, M. D., Columbus, Ohio

B. SMOKING AS A SPECIAL PROBLEM IN THE AGED

Edward Cuyler Hammond, Sc.D., New York City

Ross C. Kory, M. D., Milwaukee

John R. Talbot, M. D., Madison

3. Noon Luncheons

Luncheons on internal medicine (Frederick J. Stare, M. D., Boston), and many others will be presented. Full details on all scientific luncheon programs during the Annual Meeting will be publicized in the future. While certain of the luncheons serve as official luncheons for specialty organizations, they are open to all members of the State Medical Society so long as seating is available.

4. Nutritional Problems of the Aged

A. GENERAL PRINCIPLES, THE HAZARDS OF FADDISM AND QUACKERY, AND PRACTICAL POINTS: Frederick J. Stare, M. D., Boston (Conrad A. Elvehjem Memorial Lecture)

B. DIET AND CARDIOVASCULAR DISEASE: J. Stamler, M. D., Chicago

C. DIET AND SERUM CHOLESTEROL IN THE AGED: William E. Connor, M. D., Iowa City

5. Osteoarthritis and Osteoporosis

A. CURRENT CONCEPTS OF OSTEOARTHRITIS AND OSTEOPOROSIS: Richard H. Ferguson, M. D., Rochester, Minnesota

6. Psychiatric Aspects of Aging

A. PSYCHIATRIC ASPECTS OF PREPARATION FOR DEATH: Elihu S. Howland, M. D., Chicago

B. THE MINISTER AND THE DOCTOR MEET: Granger E. Westberg, D. D., Chicago

WEDNESDAY, MAY 8

1. General Scientific Program

A. MOST RECENT DEVELOPMENTS IN CHEMOTHERAPY IN THE TREATMENT OF CARCINOMA (Panel) "Regional Chemotherapy for Cancer": (Speaker to be named) Discussants: A. R. Curreri, M.D., Madison, John Hurley, M. D., Milwaukee

B. FREQUENT EMOTIONAL CRISES OF PATIENTS AND THEIR FAMILIES: John Romano, M. D., Rochester, New York

C. THE ANTIBIOTIC THERAPY OF BACTERIAL ENDOCARDITIS: J. E. Geraci, M. D., Rochester, Minnesota

2. Noon Luncheons

Luncheons on radiology (Frank L. Campeti, M. D., Rochester, N.Y.), fevers (J. E. Geraci, M. D., Rochester, Minn.), pathology (E. Val Hastings, M. D., Augusta, Ga.), obstetrics (Ben Peckham, M. D., Madison), psychiatry (John Romano, M. D., Rochester, N.Y.), cancer (Speaker to be named) and electrocardiography (Richard H. Wasserburger, M. D., Madison).

3. Afternoon Scientific Programs

A. OBSTETRICS AND GYNECOLOGY

"Selection of Treatment of Gynecologic Malignancies", Clyde L. Randall, M. D., Buffalo, N.Y.

B. PATHOLOGY

"Collagen Disease: Morphology and Pathology", E. Val Hastings, M. D., Augusta, Ga. Panel on Collagen Diseases: Charles Altshuler, M. D., Paul Kimmelstiel, M. D., and John Smith, M. D., all of Milwaukee

C. PSYCHIATRY

"The Psychiatric Referral and Other Aspects of Relationship Between the Psychiatrist

and the Referring Physician", John Romano, M. D., Rochester, N.Y.

"Specificity in Psychosomatic Disease", David T. Graham, M. D., Madison

D. RADIOLOGY

"Esophageal Hiatus Hernia", Frank L. Campeti, M.D., Rochester, N.Y.

"Roentgenological Diagnosis of Intrathoracic Disease", Lawrence A. Davis, M. D., Louisville, Ky.

THURSDAY, MAY 9

1. Medical Aspects of Sports

A. KNEE INJURIES: Robert W. Bailey, M. D., Ann Arbor, Mich.

B. COMMON DERMATOLOGIC PROBLEMS ASSOCIATED WITH SPORTS AND HOW BEST TO MEET THEM: C. G. Mendelson, M. D., Detroit, Mich.

2. Noon Luncheons

Luncheons on anesthesiology (John J. Bonica, M. D., Seattle, Wash.), EENT (Peter C. Kronfeld, M. D., Chicago, and Lawrence R. Boies, M. D., Minneapolis), orthopedics (Robert W. Bailey, M. D., Ann Arbor, Mich.), public health (Peter C. Kronfeld, M. D., Chicago), dermatology (C. G. Mendelson, M. D., Detroit), pediatrics (Herbert A. Wenner, M. D., Kansas City), and several others.

3. Afternoon Scientific Programs

A. ANESTHESIOLOGY

"Anesthesia for Infants," Robert M. Smith, M. D., Boston, Mass.

"Regional Anesthesia in Children", John J. Bonica, M. D., Seattle, Wash.

"Anesthesia for Poor Risk Pediatric Patients", Robert M. Smith, M. D., Boston, Mass.

B. OPHTHALMOLOGY AND OTOLARYNGOLOGY

"Current Trends in Otolaryngology," Lawrence R. Boies, M. D., Minneapolis, Minn.

"Recent Developments in Glaucoma Surgery," Peter C. Kronfeld, M. D., Chicago, Ill.

C. PEDIATRICS

"New Virus Diseases in Pediatrics", Herbert A. Wenner, M. D., Kansas City, Kansas

"Metabolic Disorders in Children", Harry A. Waisman, M. D., Madison

"Anesthesia for Poor Risk Pediatric Patients", Robert M. Smith, M. D., Boston, Mass.

D. SURGERY

"An Analysis of Fractures and Dislocations of the Spine", Robert W. Bailey, M. D., Ann Arbor, Mich.

"Portal Hypertension—Management of Bleeding and Ascites", Ivan D. Baronofsky, M. D., San Diego, Cal.

OUT-OF-STATE GUEST LECTURERS

Ormand C. Julian, M. D., Chicago
George Hamwi, M. D., Columbus, Ohio
E. Cuyler Hammond, Sc. D., New York City
Frederick J. Stare, M. D., Boston
J. Stamler, M. D., Chicago
William E. Connor, M. D., Iowa City
Richard H. Ferguson, M. D., Rochester, Minn.
Elihu S. Howland, M. D., Chicago
Frank L. Campeti, M. D., Rochester, N.Y.
Clyde L. Randall, M. D., Buffalo, N.Y.
Peter C. Kronfeld, M. D., Chicago
Lawrence R. Boies, M. D., Minneapolis
C. G. Mendelson, M. D., Detroit
Herbert A. Wenner, M. D., Kansas City
Lawrence A. Davis, M. D., Louisville, Ky.
Robert M. Smith, M. D., Boston

MARQUETTE UNIVERSITY SCHOOL OF MEDICINE 50TH ANNIVERSARY

The Annual Meeting program this year will honor Marquette University School of Medicine on its Fiftieth Anniversary. Edward R. Annis, M. D., Miami, Florida, President-Elect of the American Medical Association, an alumnus of the school, will attend the meeting and six other alumni have been invited to be out-of-state guest lecturers in the scientific programs of the Annual Meeting.

ROBERT W. BAILEY, M. D.
(Class of 1946), Department of Orthopedic Surgery, University of Michigan Medical School, Ann Arbor, Mich.

IVAN D. BARONOFSKY, M. D.
(Class of 1943), Clinical Professor of Surgery, University of Southern California School of Medicine, San Diego, Calif.

JOHN J. BONICA, M. D.
(Class of 1942), Professor and Chairman, Department of Anesthesiology, University of Washington School of Medicine, Seattle, Wash.

J. E. GERACI, M. D.
(Class of 1942), Clinical Section, Mayo Clinic, Rochester, Minn.

E. VAL HASTINGS, M. D.
(Class of 1944), Assistant Professor of Pathology, Medical College of Georgia, Augusta, Ga.

JOHN ROMANO, M. D.
(Class of 1934), Professor of Psychiatry and Psychiatrist-In-Chief, Strong Memorial Hospital, University of Rochester School of Medicine, Rochester, N.Y.

EDWARD R. ANNIS, M. D.

A Special Annual Meeting Feature

MEDICAL ART SALON

SPONSOR: The Woman's Auxiliary to the State Medical Society of Wisconsin

CO-CHAIRMEN: Dr. and Mrs. Harry Foerster, Jr.,, and Dr. and Mrs. William F. Hovis, Jr., Milwaukee

MILWAUKEE AUDITORIUM . . . MAY 6–9, 1963

Sculptures and Paintings (watercolors and oils only)

WHO MAY EXHIBIT: Any member of the State Medical Society of Wisconsin or his wife.

LIMITED ENTRIES: Up to 3 entries per person.

DEADLINE FOR ENTRIES: All notifications of "Intent to Exhibit" must be in the hands of Dr. and Mrs. Harry Foerster, Jr., Milwaukee, on or before April 1, 1963. (Early notification will be appreciated, so that proper facilities for the entire exhibit can be planned in advance. Mail your entry blank below as soon as possible.)

REQUIREMENTS: (1) All pictures must be framed with wire and screw eyes attached. (2) Works of sculpture must not exceed 24 inches in height. (3) All entries must be delivered to the Dressing Room on the east side of the stage of Bruce Hall, Milwaukee Auditorium between 8:00 a.m. and 10:00 a.m., Monday, May 6, and must be picked up in the display area between 3:30 p.m. and 5:00 p.m., Thursday, May 9.

JUDGING AND AWARDS: Ribbons for first, second, and third places in each of the three categories (sculpture, watercolor painting, oil painting) will be awarded, plus a "popularity award" based on votes of all those who view the Art Salon.

LIMITED LIABILITY: The submitter must assume full responsibility for work submitted, but every care against damage or theft will be exercised. Guard will be provided during the course of the display.

NOTIFICATION OF INTENT TO EXHIBIT

Mail to Dr. and Mrs. Harry Foerster, Jr., 4830 N. Oakland Ave., Milwaukee 17, Wis., BEFORE APRIL 1, 1963.

I plan to submit the following entry or entries for the 1963 MEDICAL ART SALON at the Milwaukee Auditorium, May 6–9.

My entry, or entries, will be:

(1) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(2) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(3) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(1) Sculpture __ Title _____ size _____" wide and _____" high

(2) Sculpture __ Title _____ size _____" wide and _____" high

(3) Sculpture __ Title _____ size _____" wide and _____" high

Name: _____ Street: _____

City: _____

MEMBERSHIP REPORT AS OF NOVEMBER 30, 1962

Society Records

NEW MEMBERS

Thomas H. Alt, 59 Racine Street, Menasha.
Dorothy M. Barbo, 8700 West Wisconsin Avenue, Milwaukee.
Anthony F. Cafaro, Waukesha Memorial Hospital, Waukesha.
Roland H. Corbet, 1835 Melody Lane, Brookfield.
John E. Dooley, 5589 North Bay Ridge Avenue, Milwaukee 17.
M. J. Falk, 1551 Dousman Street, Green Bay.
Glenn E. Gustafson, Jr., 222 Washington Avenue, Menasha.
Daniel R. Hansen, 132 Beloit Street, Walworth.
Phillip A. Hoffman, 2707 Marshall Court, Madison 5.
O. S. Keiser, Main Avenue, De Pere.
Charles J. Kienzle, 1128 West Mitchell, Milwaukee.
J. P. La Flare, 984 14th Avenue, Green Bay.
T. R. Leicht, 130 East Walnut Street, Green Bay.
Isidro L. Maranan, 5118 North 39th Street, Milwaukee.
E. Grady Mills, 915 East Summit Avenue, Oconomowoc.
R. K. Mohanty, 705 South 28th Street, Milwaukee 15.
Arlan L. Rosenbloom, 1300 University Avenue, Madison 6.
Edward C. Saltzstein, 836 North 12th Street, Milwaukee.
F. G. Sehring, 1551 Dousman Street, Green Bay.

CHANGES OF ADDRESS

Harry Ageloff, to 524 Main Street, Racine.
John M. Albino, to 438 Shoreland Drive, Racine.
J. Neil Boger, Milwaukee, to St. Joseph's Hospital, Marshfield.
Bruce Bogost, to 3839 West Fond du Lac Avenue, Milwaukee.
Elvin M. Bremer, Milwaukee, to 912 Hogy's Ford Road, Narberth, Pa.
Christo Christoff, to 30 West Chicago Avenue, Chicago 10, Ill.
K. W. Covell, to 500 Walton Avenue, Racine.
Donald P. Davis, Topeka, Kan., to 328 Johnson Street, Carlinville, Ill.
Robert E. Fitzgerald, Janesville, to 135 Kenilworth Avenue, Elmhurst, Ill.
F. M. Hilpert, 500 Walton Avenue, Racine.
Rateb Homsi, to 2218 North Third Street, Milwaukee 12.
Donald T. Hughson, Brookfield, to 10425 West North Avenue, Milwaukee.
Anthony M. Kowalski, Atwater, Calif., to 1424 Lancaster Place, Topeka, Kan.
E. P. Lauerman, to 500 Walton Avenue, Racine.
E. L. MacVicar, 500 Walton Avenue, Racine.
Don H. Martin, Milwaukee, to 8640 North Regent Street, Fox Point 17.
F. N. Nimz, to 1308 South 74th Street, Milwaukee 14.
Mae J. O'Donnell, Wadsworth, Kansas, to V. A. C. C., Excelsior Springs, Mo.
Archie Pequet, to 10425 West North Avenue, Milwaukee.
E. B. Pfefferkorn, to 533 Mt. Vernon Street, Oshkosh.
G. P. Santos, to 1124 East Pershing Street, Appleton.
J. J. Sharpe, to 150 East First Street, Fond du Lac.
Eleanor C. Struck, to Route 2, Box 347, West Bend.
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*Levin, S. J.: **Pediat. Clin. North America** 1:975, Nov., 1954.

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CALENDAR OF MEETINGS

1963 **Wisconsin**

Feb. 1–3: Annual scientific meeting, Wisconsin Psychiatric Association, Dell View Hotel, Lake Delton.

Feb. 6: SMS postgraduate course on Clinical Electrocardiography (Dr. Richard Wasserburger), St. Luke's Hospital, Racine (AAGP credit).

Feb. 7: Postgraduate course on Topics of Current Interest in the Care of the Newborn, University of Wisconsin Medical Center, Madison.

Feb. 13–14: Postgraduate course on Recent Advances in Gynecology and Obstetrics, Marquette University School of Medicine, Milwaukee.

Feb. 17–23: Wisconsin Work Week of Health, SMS headquarters, Madison.

Feb. 26: SMS circuit teaching program (surgery: Dr. G. E. Collentine; medicine: Dr. Burton Waisbren; pediatrics: Dr. Gerald Kerrigan), St. Vincent's Hospital, Green Bay (AAGP credit).

Feb. 27: SMS circuit teaching program (same as above), Langlade County Memorial Hospital, Antigo (AAGP credit).

Mar. 7: Postgraduate course on Some Orthopedic Problems Occurring in General Practice, University of Wisconsin Medical Center, Madison.

Mar. 7–9: Postgraduate course on The Hemiplegic Patient, University of Wisconsin Medical Center, Madison.

Mar. 8: Public lecture on The Brain, Too, Has Arteries, Dr. Paul Dudley White, Boston at 4 p.m., University of Wisconsin Medical School, Madison.

Mar. 20: Poison control seminar, sponsored by State Board of Health and others, at State Medical Society headquarters, Madison.

Mar. 21–23: Postgraduate course on Advances in Immunology and Hypersensitivity, University of Wisconsin Medical Center, Madison.

Mar. 27: SMS teaching program on Strokes, Janesville.

April 3–5: Seminar on Bobath Approach to the Treatment of Cerebral Palsy, Central Wisconsin Colony and Training School, Madison.

Apr. 4: SMS teaching program on Clinical Electrocardiography, Oshkosh.

April 18–19: Annual meeting, Wisconsin Anti-Tuberculosis Association, Pfister Hotel, Milwaukee.

Apr. 18–20: Health Fads and Fallacies symposium, State Medical Society headquarters, Madison.

April 25–27: Postgraduate course on Renal Diseases in Childhood, University of Wisconsin Medical Center, Madison.

May 6–9: State Medical Society of Wisconsin annual meeting, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

1963 **Out-of-State**

Feb. 11–15: Postgraduate course on Modern Physiological Concepts of Cardiovascular Disease, Presbyterian Medical Center, American College of Physicians, Presbyterian Medical Center, San Francisco, Calif.

Feb. 12–14: Continuing education course on Growth and Development—Management of Common Behavior Disturbances, Medical College of Georgia, Augusta, Ga.

Mar. 4–6: Meeting of Canadian-American Medical and Dental Ski Association, Iroquois Mountain, Brimley, Mich.

Mar. 4–7: Annual meeting of the New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La.

Mar. 4–8: Postgraduate course on Physical Methodology in Medical Research, Massachusetts Institute of Technology, American College of Physicians, Massachusetts Institute of Technology, Cambridge, Mass.

Mar. 8–9: AMA Medicolegal Symposium, Americana Hotel, Miami Beach, Florida.

Mar. 11–13; 18–20: Clinical Reviews, Mayo Clinic and Mayo Foundation for Medical Education and Research, Mayo Civic Auditorium, Rochester, Minn.

Mar. 11–14: Annual sectional meeting, American College of Surgeons, Penn-Sheraton Hotel, Pittsburgh, Pa.

Mar. 16–21: Fifteenth Annual Teaching Seminar of the International Academy of Proctology, Las Vegas, Nev.

Mar. 18–21: American Industrial Health Conference, Sheraton-Park Hotel, Washington, D.C.

Mar. 18–23: Postgraduate course on Recent Advances in Cardiovascular Disease, American College of Physicians, The Mount Sinai Hospital, New York.

Mar. 24–29: American College of Allergists Graduate Instructional Course and Nineteenth Annual Congress, Americana of New York, New York City.

Mar. 25–29: American Society of Anesthesiologists Biennial Western Conference on Anesthesiology, Hawaiian Village, Honolulu.

Mar. 28–30: Fourth Oklahoma Colloquy on Advances in Medicine: Pulmonary Insufficiency, Oklahoma City, Okla.

June 10–13: Convention of the Catholic Hospital Association of the United States and Canada, Conrad Hilton Hotel, Chicago.

Medical Meetings
Postgraduate Courses

University of Wisconsin Medical School

Dr. Paul Dudley White, Boston, will speak on "The Brain, Too, Has Arteries" in a public lecture March 8 at 4 p. m. at the University of Wisconsin Medical School. His appearance will be sponsored by the Wisconsin chapter of Alpha Omega Alpha, honorary medical society.

Wisconsin Psychiatric Association

"The Psychiatric Emergency" will be the theme of the fifth annual scientific meeting of the Wisconsin Psychiatric Association scheduled for Friday, Saturday and Sunday, February 1, 2 and 3, at the Dell View Hotel, Lake Delton.

Scientific and social functions will be open to all interested members of medical, psychology, social work and other mental health professions. Dr. Charles W. Landis, Milwaukee, president, will preside.

Friday's scientific program on "The Suicidal Patient, Suicide Prevention" will have Dr. William C. Lewis, Madison, as chairman. Included in the program will be "Provocation of Suicidal Attempts," by Dr. Carl H. Fellner, Madison, with Dr. Norman D. Tabachnick, Beverly Hills, Calif., discussant; "Failure and Masochism," by Doctor Tabachnick, with Dr. M. Donald Coleman, New York City, discussant; and an informal discussion by Doctor Tabachnick of the work of the Los Angeles suicide prevention center.

"Crisis Theory, Family and Individual Crisis Situations" will be the subject of Saturday morning's scientific program. It will include "Crisis Theory: a Review," by Dr. B. Cullen Burris, Milwaukee; "Crisis Theory in Application: Management of the Schizophrenic Exacerbation," by Dr. Milton H. Miller, Madison; and "Study of Patient Reactions to a Recent International Crisis," by Dr. Herman P. Gladstone, Madison.

The Saturday afternoon program will be "The Acutely Ill Patient—In or Outside the Hospital," with Dr. John F. Koppa, Madison, chairman. It will include "The Psychiatric Walk-in Clinic: Some Observations after Six Years of Operation," by Doctor Coleman, with Doctor Tabachnick as discussant, and "Utilization Patterns of Treatment Resources Within a County in Wisconsin," by Dr. Ralph H. Archer, Waunakee, division of mental hygiene, State Board of Health, and Drs. Charles A. Wunsch and James F. Caffrey, Green Bay.

Dr. Leonard J. Ganser, Madison, director of the division of mental hygiene of the State Board of Health, will discuss "Advisory Committees and Mental Health Planning in Wisconsin" at the Saturday evening banquet.

Meeting of the Council and the annual business meeting of the Association, including election of officers, will take place Sunday morning.

Reservations may be made through the Wisconsin Psychiatric Association, Executive Office, 756 North Milwaukee Street, Milwaukee 2, Wis.

Medical College of Georgia

The Medical College of Georgia will offer a continuing education course on "Growth and Development—Management of Common Behavior Disturbances," February 12, 13 and 14.

Albert J. Solnit, M. D., assistant professor of psychiatry and pediatrics, Yale University School of Medicine, and clinical director, Connecticut Child Study and Treatment Home, New Haven, Conn., will be the featured faculty.

Each course is acceptable for 18 hours of credit by the American Academy of General Practice. Registration will be limited to a small group for close faculty-participant communication; the registration fee is $50. Application may be made by contacting Dr. Claude-Starr Wright, Director, Department of Continuing Education, Medical College of Georgia, Augusta, Ga.

TENTATIVE SCHEDULE—ORTHOPEDIC FIELD CLINICS

January 1, 1963–June 30, 1963

STATE DEPARTMENT OF PUBLIC INSTRUCTION
BUREAU FOR HANDICAPPED CHILDREN—CRIPPLED CHILDREN DIVISION
MADISON 3, WISCONSIN

Location	*Date*	*Location*	*Date*
Ashland	February 13 and 14	Chippewa Falls	April 24 and 25
Manitowoc	February 20 and 21	La Crosse	May 1 and 2
Racine	March 6 and 7	Rhinelander	May 8 and 9
Marinette	March 13	Superior	May 16
Kenosha	March 20 and 21	Sheboygan	May 22 and 23
Eau Claire	March 27 and 28	Lancaster	June 12
Wausau	April 16	Darlington	June 13

FOR: Clinics conducted by the Crippled Children Division of the Bureau for Handicapped Children are for persons under 21 years of age, who are referred by their family physician for orthopedic diagnosis and consultation. The reports of the examinations are then sent to the referring physician following the clinic.

REFERRAL FORMS: Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for the individual clinic so when requesting same be sure to state approximately how many forms are needed and for which clinic or clinics. It is important that we know well in advance the number of persons desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral form will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 122 West Mifflin Street, Madison 3, Wisconsin.

New Orleans Graduate Medical Assembly

The 26th annual meeting of The New Orleans Graduate Medical Assembly will be held March 4, 5, 6 and 7 with headquarters at the Roosevelt Hotel.

Nineteen outstanding guest speakers will participate in the program which will include 55 discussions on topics of current medical interest in addition to clinicopathologic conferences, symposia, medical motion pictures, round-table luncheons and technical exhibits.

Following the meeting in New Orleans, arrangements have been made for a clinical tour to Mexico leaving New Orleans by air on March 8. The itinerary will include Mexico City, Cuernavaca, Taxco and Acapulco, with return on March 23.

Details of the New Orleans meeting and the tour are available at the office of the Assembly, Room 105, 1430 Tulane Avenue, New Orleans 12, La.

American College of Surgeons

The annual four-day sectional meeting of the American College of Surgeons planned for surgeons, graduate nurses and other qualified medical personnel will be held March 11 through 14 in Pittsburgh, Pa. The meeting, which is an exchange of information between medical and nursing services, will have the Penn–Sheraton Hotel as headquarters for the physicians' sessions and the Pittsburgh–Hilton Hotel as headquarters for the nurses' sessions.

The surgical program approaches in scope the annual Clinical Congress, with sessions in general surgery and all the surgical specialties including plastic surgery, neurosurgery, ophthalmology, otolaryngology, orthopedic surgery, obstetrics and gynecology, thoracic surgery, proctology and urology.

There will be five daily "How I Do It" clinics, nonoperative, instructional demonstrations by noted surgeons, 68 scientific papers, 26 panels, 18 symposia, selected films, and industrial exhibits.

Nurses' sessions will discuss problems of special interest to the nursing profession, and nurses may also attend portions of the surgical program of interest to them. Nurses will be guests of the College and will pay no registration fee.

The final 1963 sectional meeting will be in Toronto, April 25 through 27. The annual Clinical Congress will be held in San Francisco, October 27 through November 1.

University of California School of Medicine

The UCLA School of Medicine will offer three international Clinical Postgraduate Programs this spring, as follows:

Mexico City _____February 20–March 2
Israel and Greece _____March 16–April 7
Japan and Hong Kong _____April 12–May 4

All programs will be presented in cooperation with medical schools and hospitals in the areas

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The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservations at the Palmer House.

visited and instruction will be primarily by faculty members of the local medical schools, supplemented by faculty members of the UCLA School of Medicine.

The program in Mexico City is being presented for the fourth year and those in the Orient and the Middle East for the second year.

Further information may be obtained by writing to Continuing Education in Medicine and Health Sciences, UCLA Medical Center, Los Angeles 24, Calif.

Bobath Seminar and Workshop

A seminar on the Bobath Approach to the Treatment of Cerebral Palsy will be conducted by Dr. Karl Bobath and Mrs. Berti Bobath at the Central

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Wisconsin Colony and Training School at Madison April 3, 4 and 5.

Physicians having responsibility for and interest in program planning for the cerebral palsied and university faculty whose primary responsibility is the professional training of physical therapists, occupational therapists and speech therapists may attend.

The seminar will include a study of the normal and abnormal reflex patterns, including neuroanatomy, physiology and pathology, and their relation to cerebral palsy. The theoretical development, rationale, and application of the Bobath approach to cerebral palsy will be explained.

Fee for the seminar is $25. Inquiries may be addressed to Mr. Harvey A. Stevens, Superintendent, Central Wisconsin Colony and Training School, Box 3128, Madison 4, Wis.

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MEDICAL MEETINGS *continued*

American Thoracic Society

The American Thoracic Society will hold its annual meeting in Denver, Colo., May 13 to 15, in conjunction with the 59th annual meeting of the National Tuberculosis Association.

Wisconsin Anti-Tuberculosis Association

The 1963 annual meeting of the Wisconsin Anti-Tuberculosis Association will be held at the Pfister Hotel, Milwaukee, on April 18 and 19.

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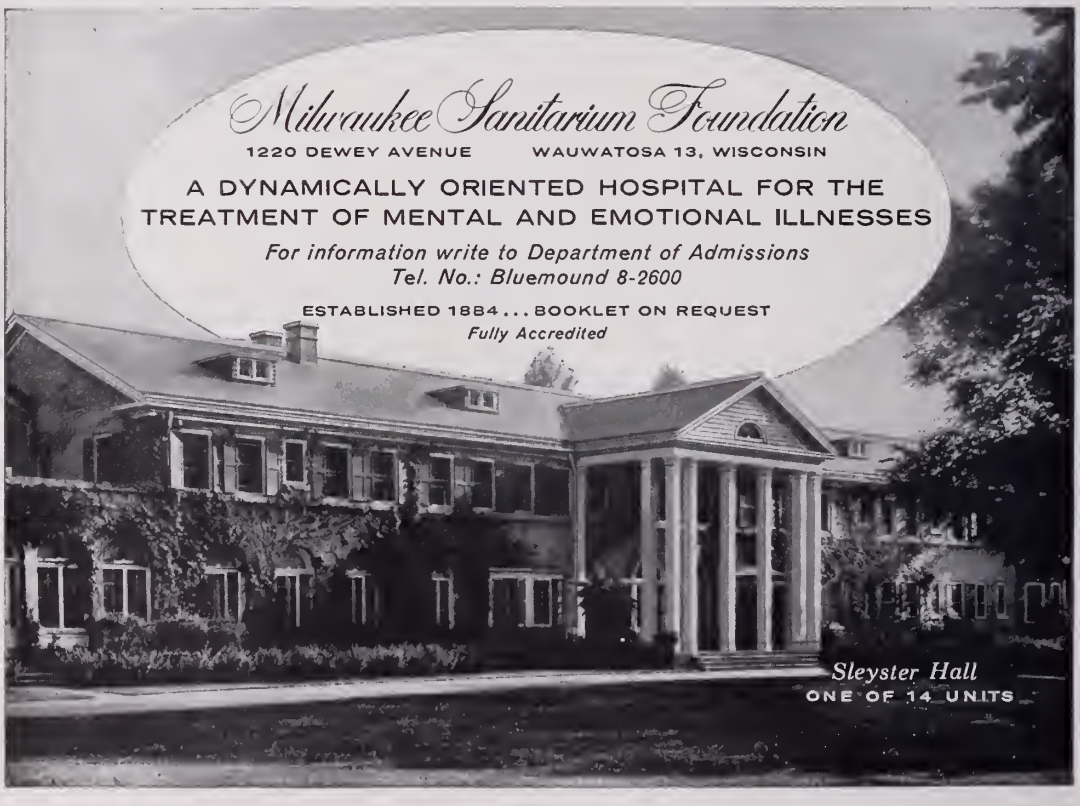

Announcing THE TWENTY-SIXTH ANNUAL MEETING OF

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters—Roosevelt Hotel—March 4, 5, 6, 7, 1963

GUEST SPEAKERS

John R. Haserick, M. D., Cleveland, Ohio
DERMATOLOGY
Henry J. Tumen, M. D., Philadelphia, Pa.
GASTROENTEROLOGY
Logan T. Robertson, M. D., Asheville, N. C.
GENERAL PRACTICE
Andrew A. Marchetti, M. D., Washington, D. C
GYNECOLOGY
Raymond D. Pruitt, M. D., Houston, Texas
INTERNAL MEDICINE
Paul S. Rhoads, M. D., Chicago, Ill.
INTERNAL MEDICINE
C. H. Hardin Branch, M. D., Salt Lake City, Utah
NEUROPSYCHIATRY
J. Robert Willson, M. D., Philadelphia, Pa.
OBSTETRICS
James I. Moore, M. D., Baltimore, Md.
OPHTHALMOLOGY
James E. Bateman, M. D., Toronto, Ont., Can.
ORTHOPEDIC SURGERY
Joseph H. Ogura, M. D., St. Louis, Mo.
OTOLARYNGOLOGY
Edward A. Gall, M. D., Cincinnati, Ohio
PATHOLOGY
Weston M. Kelsey, M. D., Winston-Salem, N. C.
PEDIATRICS
Curtice Rosser, M. D., Dallas, Texas
PROCTOLOGY
Ted F. Leigh, M. D., Atlanta, Ga.
RADIOLOGY
John L. Keeley, M. D., Chicago, Ill.
SURGERY
John L. Madden, M. D., New York, N. Y.
SURGERY
Edwin P. Alyea, M. D., Durham, N. C
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For information concerning the Assembly meeting and the tour write Secretary, Room 105, 1430 Tulane Avenue, New Orleans 12, La.

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State Medical Society Teaching Program

A postgraduate teaching program on "Strokes—What Can We Do About Them?" will be given at Mercy Hospital, Janesville, from 2 to 5 p.m. March 27. The course is acceptable for three hours of Category 1 credit for members of the American Academy of General Practice.

Subjects and speakers will include: Diagnosis and Differential Diagnosis of Strokes, by Richard H. Strassburger, M.D., clinical instructor in neurosurgery, Marquette University School of Medicine; Medical Management of Strokes, by Mark J. Ciccantelli, M.D., assistant clinical professor of medicine, Marquette University School of Medicine; Surgery in Relation to Strokes, by Walter J. Woloschek, M.D., clinical instructor in surgery, Marquette University School of Medicine; and Physical Therapy and Rehabilitation of the Stroke Patient *(With particular reference to what can be done locally, where specialized rehabilitation facilities are not available)* by Edwin C. Welsh, M.D., clinical professor of physical medicine and rehabilitation, Marquette University School of Medicine.

Cooperating sponsors with the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin are the Wisconsin Academy of General Practice and the Wisconsin State Board of Health.

Mayo Clinic–Mayo Foundation

The Mayo Clinic and the Mayo Foundation for Medical Education and Research will offer two three-day sessions of Clinical Reviews in March. Identical sessions will be held March 11, 12 and 13 and March 18, 19 and 20 in the theater of the Mayo Civic Auditorium at Rochester, Minn.

Clinical Reviews is acceptable for 25 hours of Category 1 credit by the American Academy of General Practice and the College of General Practice of Canada.

Registration fee for the program is $10. Those wishing to attend should communicate with Mr. M. G. Brataas, Mayo Clinic, Rochester, Minn., and should indicate which session they prefer.

Oklahoma Tuberculosis Association

The Fourth Oklahoma Colloquy on Advances in Medicine: Pulmonary Insufficiency will be held March 28 to 30 in Oklahoma City, Okla. This series of discussions has been developed by the Department of Medicine and Division of Postgraduate Education of the University of Oklahoma School of Medicine in collaboration with the Oklahoma Tuberculosis Association and the Oklahoma Thoracic Society.

Inquiries for further information may be directed to Dr. Robert Byrd, Professor of Medicine, University of Oklahoma School of Medicine, 800 N.E. 13th, Oklahoma City, Okla.

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The usual underwriting and waiting periods will apply for individual application, but may be waived in groups.

Cost will be below $7.80 per year for a single person and $18.00 per year for a family. In addition there will be a one-time enrollment fee for those not in employed groups of 25 or more insured persons. This fee would be $3.00 for a single person and $5.00 for a family.

A $25.00 deductible will apply to each covered person under age 65 each year. For those 65 and over the deductible will be $50.00.

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Wisconsin School of Medical Assistants

PRINCIPLES OF ADVERTISING

Wisconsin Medical Journal

The acceptance of advertising in the *Wisconsin Medical Journal* is predicated on the basis that the advertised product or service meets the ethical principles established by the Council of the State Medical Society of Wisconsin. The Journal reserves the right to accept or reject advertising copy *for any reason.*

The following general rules are applicable to advertisements of medicinal preparations, apparatus or physical appliances or other products for therapeutic or diagnostic purposes or for which therapeutic, diagnostic or health claims are made:

1. The advertiser may be required to submit evidence or data in support of the usefulness of the product and the validity of the claims. The appearance of one or several papers may not necessarily be considered sufficient evidence and other data may be required.
2. Medicinal preparations containing two or more active ingredients will be considered only if in the opinion of the Advertising Committee of the Bureau there is a logical rationale for the inclusion of each active ingredient, and if a statement of the active ingredients is included in each advertisement.
3. The generic or official designation of the medicinal preparation must be adequately featured in advertising copy, in addition to the trade name.

All advertising copy is subject to the following general rules:

1. Advertisements should not be false, deceptive or misleading nor make use of sweeping superlatives.
2. Unfair comparisons and disparagement of a competitor's goods will not be allowed.
3. When excerpts from a published paper are included in advertising copy, the Bureau may require the advertiser or his agent to obtain written permission from the author and from the editor or publisher of the publication in which the paper appeared.
4. Advertising copy will not be accepted if, in the opinion of the Bureau or the management of the medical journal, the copy (a) appears to violate the Principles of Medical Ethics of the American Medical Association or of a state medical association, (b) is indecent or offensive in any way, (c) contains attacks of a personal, racial or religious character, or (d) appears to be contrary to any regulation or law for the prevention of discrimination, or (e) contains claims found by any court or federal or state agency to be invalid or in violation of law.
5. Advertisers and advertising agencies agree to protect and indemnify both Bureau and any medical journal represented by Bureau against any and all liability, loss or expense arising from claims for libel, unfair competition, unfair trade practice, infringement of trade-marks, trade names or patents, copyrights or proprietary rights, violations of rights of privacy and any other claims resulting from any advertisement submitted to the Bureau or published in any such medical journal.

The foregoing principles may be changed at any time without notice.

"Bureau" as used above refers to the State Medical Journal Advertising Bureau, Inc., Chicago.

Inquiries concerning advertising copy should be directed to,
STATE MEDICAL JOURNAL ADVERTISING BUREAU, INC., 510 North Dearborn St., Chicago 10, Illinois; BUSINESS MANAGEMENT SERVICES, INC., Park Ridge, Stevens Point, Wisconsin; or the WISCONSIN MEDICAL JOURNAL, Box 1109, Madison 1, Wisconsin.

The WISCONSIN MEDICAL JOURNAL is one of 40 state medical journals published monthly in the United States. These journals represent 47 state medical societies. Each is an official publication of the state society it represents, and is owned and operated by it.

The WISCONSIN MEDICAL JOURNAL has a circulation of 4,700. Nearly 90 per cent of the physicians in Wisconsin are subscribers. Others who receive the Journal, either complimentary or through paid subscriptions, include senior medical school students at the University of Wisconsin and Marquette University, hospital administrators, faculty members of the two medical schools, medical clinic managers, most major medical school libraries in the United States and abroad, prominent physicians in the United States, and other health organizations in Wisconsin and the United States.

Classified Advertisements

Advertisements in this section are accepted in two categories: PHYSICIANS' EXCHANGE and COMMERCIAL.

RATES: 10¢ per word, with a minimum charge of $4.00 per ad. Additional insertions of same ad at one-half price each, maximum time one year. Display: $10.00 per column inch.

DEADLINE: Copy must be received by the 15th of the month preceding month of issue. Send copy to: Wisconsin Medical Journal, Box 1109, Madison 1, Wis.; or phone Alpine 6–3101.

PHYSICIANS' EXCHANGE: This section is limited to physicians and others desiring physicion placement, sale of medical practice or equipment of a physician, sale or lease of medical buildings, etc. Advertisements from individuol members of the State Medical Society of Wisconsin are accepted without charge. Widows of deceased member physicians are ollowed to advertise without charge. The rates quoted above apply to ads ploced by clinics and others. There is no additional charge for ads with Dept. numbers. For these ads, address replies to: Dept. ___, % Wisconsin Medicol Journal, Box 1109, Modison 1, Wis. Advertisers using Dept. numbers forbid the disclosure of their identity. All inquiries are forwarded to them immediately.

COMMERCIAL: Advertisements are accepted at the above rotes from individuals, firms, organizations, etc., who are reputable, have a good credit rating and advertise products or services of ethicol standards. The Journol reserves the right to reject any advertising. Advertisements from member physicians are also occepted at the above rates.

PHYSICIANS' EXCHANGE

WANTED: PHYSICIAN AND SURGEON in Bottineau, North Dakota. Very good town, and larger practicing territory to draw from. Sigurd Sigurdson, Bottineau, N. D. p1

WANTED: PSYCHIATRISTS or young doctors, interested in psychiatry to work at Mendota State Hospital. These positions are permanent and under Civil Service; salary depends upon previous experience and training. Housing available on grounds. Contact W. J. Urben, M.D., Superintendent, Madison 4, Wis. g10tfn

FOR SALE: UNOPPOSED small town general practice, southwestern Wisconsin. Modern, well equipped, air conditioned building, excellent open staff hospital nearby. Annual gross over $50,000. Contact Dept. 999 in care of the Journal. m8tfn

WANTED: ASSOCIATE IN GENERAL PRACTICE. Established practice in Minocqua resort area which is showing rapid growth, boasts good grammar schools and three-year-old million dollar high school, 20-bed hospital with open staff and nearly completed new addition which will double bed capacity. Own clinic building which consists of waiting room, business office, five examining rooms, laboratory. Salary for first year $1,000 per month. Second year salary plus percentage of gross. Partnership at five years. Start now. Contact Dept. 997 in care of the Journal. m7tfn

FOR SALE: Two level home and office on bank of river; 45-acre estate near town of 6,000, 70 miles north of Madison. Hospital, good schools, several churches. Man with surgical training desirable. Purchase may be made by land contract. Might consider a locum tenens with potential permanent arrangement. A highly flexible opportunity for the right person. Contact Dept. 23 in care of the Journal. m12tfn

WANTED: GENERAL PRACTITIONER as associate. Immediately available opportunity to practice in well established group of two. Replacement for sudden loss of partner. Eventual partnership. 126 E. Main Street, Madison. AL 6–3171. m9tfn

FOR SALE: GENERAL PRACTICE in small town in Wisconsin. Will introduce and accept reasonable offer. Contact Dept. 14 in care of the Journal. m10tfn

URGENTLY NEEDED: General practitioner for association with three physicians, to start as soon as possible. Central Wisconsin city. Salary—the going rate—with $1,000 per month minimum, and partnership as soon as mutually desired. Contact Dept. 984 in care of the Journal. m5tfn

POSITION WANTED: RADIOLOGIST, Board eligible, University training in diagnosis and therapy, hospital and private practice experience, desires position with hospital or association. Contact Dept. 995 in care of the Journal. m7tfn

POSITION WANTED: RADIOLOGIST, certified, seeks position preferably in solo practice. Experienced, University-trained. Contact Dept. 979 in care of the Journal. 4tfn

FOR SALE: Established EENT practice, over 40 years in the heart of Milwaukee. Excellent referrals; will introduce; retiring. Contact Dept. 24 care of the Journal. m12tfn

FOR SALE: Cystoscopic table in very good condition. Name your price. Call or write Badger Medical Supply Co., 702 S. Park St., Madison, Wis., ALpine 6–1801. 12–2

WANTED: INTERNIST, Board certified, to join two established surgeons. Excellent office facilities. Opposite 300-bed hospital—200-bed added expansion in progress. Town of 15,000. Central Wisconsin. Guaranteed salary. Percentage and partnership early prospects. Contact Dept. 981 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER to associate with two young general practitioners in established three-man clinic, located in west central Wisconsin. Excellent new facilities built to handle growing practice. Hospital and recreational facilities excellent. Early partnership for right man. Contact Dept. 996 in care of the Journal. m7tfn

WANTED: PEDIATRICIAN for newly organized group in Fox River Valley of Wisconsin. One other pediatrician in community of 45,000. Excellent living conditions, noted recreational area and above average opportunity. Salary two years, then partnership. Contact Dept. 6 in care of the Journal. m9tfn

GENERAL PRACTICE FOR SALE. Physician desiring own x-ray equipment may purchase radiographic, fluoroscopic and therapy equipment. Seven-room office on main corner in southern Wisconsin city of 35,000 occupied for over 40 years. Wish to retire. Reasonable price. Contact Dept. 19 in care of the Journal. m11tfn

PARTNER IN GENERAL PRACTICE WANTED in Green Lake county, town of 5,000. Fifty-bed private hospital. Five grade schools and one high school. No predominant nationalities. Various churches. Main occupations are leather, fur and metal. Contact Dept. 20 in care of the Journal. m11tfn

GENERAL PRACTITIONER and surgeon wishes young physician for partnership agreement in southeastern Wisconsin community of 20,000. Good hospital. Contact Dept. 991 in care of the Journal. m6tfn

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WANTED: INTERNIST, Board certified or eligible for association with young internist in southeastern Wisconsin city of 90,000. Contact Dept. 980 in care of the Journal. m4tfn

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FOR SALE: IN WISCONSIN. General practice, well established, same location 40 years, fully equipped 7-room office. Will take any reasonable offer and finance as you wish. Poor health forces retirement. Contact Dept. 912 in care of the Journal. m4tfn

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WANTED: PHYSICIAN to share a clinic which is now occupied by an M.D. and a D.D.S., located in a prosperous southeastern Wisconsin industrial and farming community where the need for another physician is very great. Contact Dept. 827 in care of the Journal. 4tfn

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FOR SALE: PEDIATRICS PRACTICE in suburb of large Wisconsin city; will introduce; buyer assume two-year lease; open hospital staff; physician leaving Sept. 1, 1962, for academic post. Contact Dept. 985 in care of the Journal. m5tfn

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FOR SALE: G. E. Cardioscribe, Type 1, DWB; hospital surgical instruments; Audiograph dictating machine. Contact Mrs. J. S. Supernaw, 6100 Midwood Avenue, Madison. m11tfn

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WANTED: GENERAL PRACTITIONER. Milwaukee, Wisconsin. General practitioner desires associate. First year, salary; then profit percentage leading to partnership. Contact Dept. 957 in care of the Journal. m12tfn

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WANTED: ONE OR TWO general practitioners and surgeons, singly or a team, to fill void left by death of two physicians. Twenty-seven bed hospital well equipped located in village surrounded by large rural area. No other physicians in community. Contact J. H. Twetan, Iola, Wisconsin. 6tfn

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WANTED: GENERAL PRACTITIONER to become associated with small group in central Wisconsin, preferably one who has had some practical experience, and has a special interest in obstetrics; also willing to only assist in surgery. Contact Dept. 969 in care of the Journal. m2tfn

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WANTED: GENERAL PRACTITIONER as a replacement in town of 1,275 in southern Wisconsin. Gross receipts $42,000 in 1961, over $24,000 first 6 months 1962. Unopposed, good schools, churches, roads, fishing. Nearby accredited 200 bed hospital. Leaving for residency. Contact: D. L. Minter, M.D., Clinton, Wis. m9tfn

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WANTED: GENERAL PRACTITIONER to replace physician who left for residency training. Fully equipped office available immediately. Town of 2,100 offers good hospital, skiing, hunting, golf, fishing and many other recreational advantages along the Chippewa River near its junction with the Mississippi. Financial remuneration should be excellent from the start. Contact Dept. 7 in care of the Journal. m9tfn

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WANTED: GENERAL PRACTITIONER for associate with two other general practitioners in community of 2,400 with trade area of 7,000. No investment required. Excellent clinical and diagnostic facilities. 200 bed hospital 15 miles. Good educational facilities. Convenient communications to recreational areas. Contact Dept. 8 in care of the Journal. m9tfn

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WANTED: YOUNG GENERAL SURGEON for associate leading to partnership in one year if mutually agreeable. Mideastern Wisconsin. Contact Dept. 9 in care of the Journal. m9tfn

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GOOD LOCATION AVAILABLE for general practitioner. Nothing to buy. Will assist and refer all general practice cases. Contact C. A. Sholtes, M.D., Richland Center, Wis., Midway 7-2592 or 7-2544. m9tfn

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WANTED: GENERAL PRACTITIONER urgently needed to become permanent member of Wisconsin clinic with rapidly expanding medical and surgical practice. Excellent salary arrangement can be offered with early partnership. Contact Dept. 961 in care of the Journal. m8tfn

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WANTED: GENERAL PRACTITIONER to take over practice or partnership in excellent rural community. Open staff hospital. Should net $20,000 first year. Send inquiries to Dept. 17 in care of the Journal. m10-3

FOR SALE: RADIOLOGIST has for sale radiographic and therapy equipment, seven-room office occupied over 40 years in professional building main corner city of 35,000. Southern Wisconsin. Reasonable price. Contact Dept. 988 in care of the Journal. m6tfn

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FOR SALE: GENERAL PRACTICE, well trained and active, in new fully equipped clinic building. Present physician leaving for residency. Personnel well trained and efficient. Rural village 38 miles northeast of Madison. New school, swimming pool, good housing available. Subsidy can be arranged through village. Contact Joseph G. Brown, M. D., Cambria, Wisconsin. m6tfn

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FOR SALE: GENERAL PRACTICE in Chippewa Falls, Wis.; well established, same location for 17 years, fully equipped 5½-room office. Will take any reasonable offer and finance as you wish. Office help available. Practice available because of recent death of William F. Janc, M.D. Contact Mrs. William F. Janc, 300 Macomber Street, Chippewa Falls, Wis. m7tfn

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PHYSICIANS, with or without pediatric training, needed in maternal and child health program at salaries ranging from $9,960.00 to $13,200.00. Five-day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, Milwaukee Health Department, Municipal Building, Milwaukee 2, Wis. g8tfn

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WANTED: GENERAL PRACTITIONER as associate in a four-man group with adequate clinical facilities. Offer open for two or three year locum tenens or for permanent association in the group. Town of 4,000, well-equipped 80-bed hospital, in west central Wisconsin. Contact Dept. 10 in care of the Journal. m9tfn

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PHYSICIANS WANTED: Psychiatrists, general practitioners, and internist at 1176-bed accredited psychiatric hospital located in good community near Wisconsin vacationland. Good schools and community services. Usual entrance salaries range from $11,150 to $14,565. Five to six per cent increase approved and scheduled for January, 1964. Possible to attain $19,785 annual salary through periodic within-grade increases and advancement in grade. Higher entrance rates for specialists. Excellent fringe benefits include life and health insurance, retirement, vacation and sick leave with pay. Must be graduate of recognized medical school and licensed in one of the United States. Inquire: Aaron S. Mason, M.D., Hospital Director, VA Hospital, Tomah, Wis. 12-2

FOR SALE: INDEPENDENT PRACTICE in internal medicine in Marshfield, Wis., population 15,000, medical center for area of 50-mile radius and 75,000 population. Hospital of 268 beds with 105-bed addition nearly completed. Established in 1956, practice has grossed $75,000 per year for past three years. Excellent records, eight-room suite of offices, laboratory equipment available. Financial arrangements flexible. Contact Mr. Ralph Crain, 800 S. Drake Ave., Marshfield, Wis., phone area code 715, FUlton 4-2915, or C. Bruce Taylor, M.D., Department of Pathology, Evanston Hospital, Evanston, Ill., phone area code 312, UNiversity 9-2500, Ext. 760. m12tfn

PHYSICIANS WANTED: Psychiatrists and general practitioners at 1176-bed fully accredited NP hospital. Family quarters available; good schools; near Wisconsin vacationland. Salary range from $10,635.00 to $13,730.00, plus 15% specialty allowance if board certified; excellent fringe benefits. Must be graduate of recognized medical school and licensed in one of the United States. Inquire: Aaron S. Mason, M.D., Hospital Director, VA Hospital, Tomah, Wisconsin. 8–1

ALLERGIST WANTED to share offices with dermatologist. Located in thriving area, south central Wisconsin. Unusual opportunity. Applicant must be board certified or qualified and intending to become certified. Reply, with details of personal and professional qualities and qualifications, to Dept. 5 in care of the Journal. m8tfn

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WANTED TO RELOCATE: Solo general practitioner in same office over 20 years must yield present location. Prefer to locate in rural area where a GP needs assistance or wishes to retire. Will consider serving in any way compatible and fitting within the sphere of mutual concern. Any inquiries will be held confidential with no expense or obligation. Contact Dept. 18 in care of the Journal. m11tfn

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WANTED: INTERNIST for newly formed professional corporation in northeastern Wisconsin. Ideal living conditions and superior opportunity for advancement. Salary during first two years of association. Contact Dept. 25 in care of the Journal. 1tfn

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POSITION WANTED: Anesthesiologist, young, married, personable, Wisconsin-trained physician, now completing anesthesia residency, desires location and association in a progressive community requiring specialty practice July 1963. Contact Dept. 27 in care of the Journal. m1tfn

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OFFICE SUITE AVAILABLE for one or two physicians in newly completed professional building in Port Washington. Excellent hospital facilities. Contact Gerold & Huiras, Attorneys, 116 West Grand Avenue, Port Washington, Wisconsin. p11, 12–1

WANTED: YOUNG GENERAL PRACTITIONER interested in general medicine and obstetrics to associate with a small group in northwestern Wisconsin. Salary arrangement to start with early partnership. Contact Dept. 982 in care of the Journal. 5, 8tfn

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WANTED: Certified or qualified specialist in—

1. Orthopedics
2. ENT
3. Ophthalmology
4. Psychiatry
5. Proctology
6. Pediatrics
7. Neurology
8. Pathology
9. Anesthesiology

to join 26-man, all-specialist group. Contact Robert G. Zach, M.D., The Monroe Clinic, Monroe, Wis. 8tfn

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FOR RENT: OFFICE SPACE, 1200 sq. ft., for medical offices in modern, air-conditioned building at 16 East Gorham Street, Madison. Available for immediate occupancy. Will accommodate one or two physicians, preferably internists. Off-street parking. Contact Robin Allin, M.D., 1313 Fish Hatchery Road, Madison, Wis., phone ALpine 6-5521; or residence CEdar 3–2082. m8tfn

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WANTED: GENERAL PRACTITIONER with interest in surgery and obstetrics for physician now grossing over $50,000 and planning retirement within five years. To take over entire practice ultimately and now enter into partnership agreement until final termination of practice occurs. Excellent opportunity, no investment involved, full hospital privileges to qualified person. Large southeastern Wisconsin industrial city. Contact Dept. 13 in care of the Journal. m11tfn

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WANTED: EXPERIENCED GENERAL PRACTITIONER to join two young GPs, St. Paul, Minn. Progressive, ethical, remunerative practice, three open-staff hospitals, own new building completely equipped. Salary first year leading to partnership; share calls. Excellent family area with good schools. Contact Dept. 22 in care of the Journal. 12–2

FOR SALE: Pelton autoclave, model number FL2, like new, $100 ($275 cost). Contact Eugene M. Kay, M.D., 1915 W. Hampton Ave., Milwaukee, Wis. CO 4–2898. m1tfn

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FOR SALE: Northwest Chicago general practice. Complete equipment, 2,000 active patients, large annual gross. Nurses remain. Reasonable terms. Contact Dept. 28 in care of the Journal. 1–2

PHYSICIAN WANTED: General practitioner in northeastern Wisconsin wants part time help. Can use one man or combination to cover practice for week, month, or up to a year. Money no object for right man. No OB or surgery unless desired. Living facilities and car available. Contact Dept. 29 in care of the Journal. m1

WANTED: METAL HAMILTON TABLE, recent model, in good condition. Contact Dept. 30 in care of the Journal. m1tfn

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WANTED: PHYSICIAN for Wisconsin State Prison at Waupun, Wis. Eight-hour day, five-day week, retirement, civil service benefits. No office to maintain, no bills to collect, no obstetric cases. Beginning salary $10,596 to $14,196 depending upon qualifications. Salary can go to $17,796 per year. Write John C. Burke, Warden, Wisconsin State Prison, Waupun, Wis. 1–3

WANTED: PHYSICIAN to associate with two established general practitioners in southeastern Wisconsin industrial, agricultural community of 6,000. Prefer one who has had special surgical training and willing to do general practice along with surgery. Contact Dept. 31 in care of the Journal. m1–3

PRIME OPPORTUNITY for additional doctor in vigorous group of seven in general practice. County seat town of 6,000, new building with excellent x-ray, laboratory, other facilities. 60-bed municipal hospital in town JCAH accredited. Seeking man from internship, or with additional training medical or surgical, or man finishing service commitment. Excellent opportunity development one or several fields. Salary at outset, then increasing percentage to full partnership. Inquire Cantwell–Peterson Clinic, Shawano, Wis. 12–2

INTERNIST WANTED: Fourteen-man Iowa group has opening for Board qualified internist. City of 30,000, new clinic building, complete laboratory and x-ray. Partnership in two years; salary open. Contact Dept. 26 in care of the Journal. 1–3

COMMERCIAL

WANTED: Advertisements for this new section. Open for physicians, individuals, firms, organizations who have something they would like to sell, or are looking for something to buy, or have a service available, which might be of interest to physicians.

INDEX

Page

ABORTIFACIENTS, Sale of contraceptives and -- 25
ABORTION Protect yourself 26
ADVERTISING, Classified 58*
—Index to 1962 Journal advertisers 56*
—Principles of 57*

BASIC SCIENCE law 15
—list of examiners 91
BIRTHS, File certificate for 54
BLINDNESS, Law requires silver nitrate to prevent infant 26
BLOOD TESTS, Blood grouping tests for identification 35
BOARD OF HEALTH, List of officers 90
BOARD OF MEDICAL Examiners, List of officers 91
BOARD OF NURSING,, List of officers 93
BOARD OF PHARMACY, List of officers 93
BOARD OF PUBLIC WELFARE, List of officers 91
BOARD OF VOCATIONAL AND ADULT EDUCATION, List of officers 92

CALENDAR OF MEETINGS 37*
CANCER CASES, Report to State Board of Health 54
CHAPTER 301, Inspection of physician and hospital records; interpretation of 3
CHARTER LAW of medical societies in Wisconsin 56
CHILD PLACEMENT agencies 86
CHIROPODY: See Podiatry
CHIROPRACTIC, Limitations on practice 24
COMMITMENT PROCEEDINGS, Registration for reference work on 54
COMMUNICABLE DISEASES, Report to State Board of Health 54
CONTRACEPTIVES and abortifacients, Sale of-- 25
COUNTY MEDICAL SOCIETY sponsorship of health programs 8

DEATHS, How to complete a death certificate -- 42
—Reports on 54
DELEGATION OF DUTIES and functions to nurses, Physicians' guidelines for 11

EDITORIALS:
Shrine Burn Center for Children (Hill) (President's Page) 97
Our Sixtieth 98
Parsimony in Dairyland 100
EMERGENCIES, What are your rights in 12
EPILEPTICS, Drivers' licenses for 10
—Responsibility of physician conducting pre-employment examinations 52
EXAMINATIONS, Post mortem 52
—Responsibility of physician conducting pre-employment 52
EXTERNS: See Preceptees

FILMS, Medicolegal 95
FOREIGN-TRAINED PHYSICIANS, Licensing of 19
FOUNDATION: See State Medical Society

GUIDES, Interpretation of Chapter 301 3
—Interpretation of Medical Practice Act 13
—Physicians' guidelines for delegation of duties and functions to nurses 11
—University Hospitals guide for referring physicians 29

HEALTH PROGRAMS, County medical society sponsorship of 8

ILLEGITIMACY, Blood grouping test to determine identification 35
INDEX to January, 1963, issue of Journal 61*

Page

INDUSTRIAL COMMISSION, List of officers 92
INSURANCE, Professional liability; prevention and 48
—Problems of physician's widow 36
INTERNS, Legal status of 20
ITINERANTS, Legal status of 21

JURY DUTY, Physicians exempt from 36

LAWS OF WISCONSIN, Legal limitations on treating the sick in Wisconsin; interpretation of The Medical Practice Act 13
—Medical staff rules and regulations as to sterilizations 9
—Physician and hospital records retention and inspection; interpretation of Chapter 301 -- 3
—Right to use title "doctor" in Wisconsin 27
LICENSE, Can you practice without a 35
—Drivers' licenses for epileptics 10
—Legal status of doctor without permanent 19
—Licensing of foreign-trained physicians 19
Temporary 19
LICENSURE of physicians 17
LITERATURE, Medicolegal 95
LOANS available to Wisconsin medical students 37
LOCUM TENENS 50

MALPRACTICE, Problems of physician's widow 36
MALPRACTICE, Problems of physician's widow 56
MARCH OF MEDICINE, Schedule of programs -- 96
MASSAGE AND HYDROTHERAPY, Limitations on practice 22
MATERNITY HOMES, Licensed 86
MEDICAL ETHICS Principals of, American Medical Association 65
MEDICAL FORUM 101
MEDICAL LOANS and scholarships available to Wisconsin medical students 37
MEDICAL MEETINGS 37*
MEDICAL PRACTICE ACT, Legal limitations on treating the sick in Wisconsin; interpretation of 13
MEDICAL RECORDS, How long should you keep your professional case records and x-rays? 55
—Physician and hospital records retention and inspection; interpretation of Chapter 301 -- 3
—Problems of physician's widow 36
MEDICINE AND SURGERY, Licensing requirements and procedures 17
MEDICOLEGAL INFORMATION, Films, speakers, literature available 95

NARCOTICS, Annual registration 54
—Drugs subject to federal narcotics laws 43
—Preprinted prescription blanks 10
NURSES, Physicians' guidelines for delegation of duties and functions to 11

OPTOMETRY, Limitations on practice 24
ORTHOPEDIC FIELD CLINICS, Tentative schedule 38*
OSTEOPATHY, Requirements and procedures to practice 23

PATERNITY, Blood grouping test for identification 35
PHYSICAL THERAPY, Limitations on practice -- 22
PHYSICIAN RESPONSIBILITY, Can you practice without a license? 35
—How to complete a death certificate 42
—Legal limitations on treating the sick in Wisconsin; interpretation of Medical Practice Act 13
—Locum tenens 50
—Medical staff rules and regulations as to sterilizations 9
—of physician conducting pre-employment examinations 52

Page
—Physicians exempt from jury duty 36
—Post mortem examinations 52
—Problems of physician's widow 36
—What are your rights in emergencies? 12
—Your deadlines and other "musts" 53
PHYSICIANS' EXCHANGE 58*
PLACEMENT SERVICE aids doctors and communities 47
PODIATRY, Requirements to practice 23
POISON INFORMATION CENTERS, List of 51
POSTGRADUATE COURSES 37*
PRECEPTEES, Legal status of 20
PRE-EMPLOYMENT EXAMINATIONS, Responsibility of physician conducting 52
PRENATAL FACTS, Form for 79
PRESCRIPTIONS, Preprinted blanks 10
PRESIDENT'S PAGE 97

RECORDS, Retention and inspection of physician and hospital 3
—How long should you keep your professional case records and x-rays? 55
—Problems of physician's widow 36
REGISTRATION, Annual narcotics 54
—for commitment procedures 54
—in Wisconsin, Annual 54
RESIDENTS, Legal status of 20

SCHOLARSHIPS available to Wisconsin medical students 37
SPEAKERS, Medicolegal 95
STATE MEDICAL SOCIETY OF WISCONSIN:
Annual meeting, 1963, preliminary plans 16*
Charitable, Educational and Scientific Foundation, List of officers and board of trustees 94
Charter law of medical societies in Wisconsin 56
Component Council committees 1962–1963 84
Constitution and bylaws 57
Council award, Recipients of 86
Council committees 1962–1963 85
Councilor districts, Map of 80
County medical societies, List of officers and scheduled meetings 88
Members, List of 67
Officers and councilors 1962–1963 81
Officers, councilors, delegates and alternates to AMA 88
Officers of sections 84
Past presidents 87
Presidential citation, Recipients of 86
Services to members 66
Society records 35
Standing committees 1962–1963 82
Territorial legislation creating 56
STERILIZATIONS, Medical staff rules and regulations as to 9

TAXES, Do you employ four or more persons? 8
—Federal deductibility of certain health and accident insurance 64
—1962 Federal income tax notes 41
—Your deadlines and other "musts" 53
TITLE "DOCTOR", Right to use, in Wisconsin 27
TREATING THE SICK, Legal limitations on, in Wisconsin 13

UNIVERSITY HOSPITALS guide for referring physicians 29

WIDOW, Problems of physician's 36
WISCONSIN MEDICAL JOURNAL, Preparation of manuscripts for 6*
—List of Editorial staff, Editorial Board and Commission on Scientific Medicine 2
WISCONSIN PHYSICIANS SERVICE, Facts about 46*

X-RAYS, How long should you keep your professional case records and 55

INDEX TO ADVERTISERS

Page
Abbott Laboratories 10, 11
Ames Company, The 63

Barr X-ray Co., The 41
Borden's 40
Bristol Laboratories 52, 53
Burroughs Wellcome & Co., Inc. 19, 32, 33

Chatham Pharmaceuticals, Inc. 28
Chicago Medical Society 39

Davies, Rose & Company, Ltd. 21

Econo Lease of Milwaukee Medical Forum
Endo Laboratories 30

Florida Citrus Commission 51

Glenbrook Laboratories 8

Hotel Schroeder 4
House of Bidwell, Inc. 42
Hurley X-ray 42

Keeley Institute, The 41

Lederle Laboratories 47
Leeming, Thos. & Co., Inc. 9
Lilly and Company, Eli Front cover, 14

Page
Medical Protective Company, The 44
Milwaukee Sanitarium Foundation 42

National Guardian Life Insurance Co. 41
New Orleans Graduate Medical Assembly 43

Parke, Davis & Company 2, 3
Pfizer Laboratories 26, 27
Physicians' Exchange 58
Physicians Mutual Insurance Co. 4
Poythress, Wm. P. & Co., Inc. 31, 45
Professional Business Service Medical Forum

Rennebohm's 40
Robins Co., Inc., A. H. 7, 25
Roche Laboratories Back cover
Roerig & Co., J. B. 22, 23
Rogers Memorial Hospital 40

Sacred Heart Sanitarium 48
St. Croixdale Sanitarium 4
Sardeau, Inc. 24
Schering Corporation 13
Searle & Co., G. D. 15
Shorewood Sanitarium 43
Smith Kline and French Laboratories 49
Squibb & Sons, E. R. 34

Time Insurance Company Medical Forum
Tutag & Co., The 48

Wallace Laboratories 12, 29, 55
Winthrop Laboratories 20, 36, 50, 54
Wisconsin Physicians Service 46

the Wisconsin Medical Journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

Vol. 62, No. 2—FEBRUARY 1963

STATE MEDICAL SOCIETY OF WISCONSIN
MEDICINA NUSQUAM NON EST

Contents

SCIENTIFIC ARTICLES

Page

The Heart In Sarcoidosis—*Hutchinson-Boeck Granulomatosis*, by William S. Middleton, M.D., Washington, D.C. ---------- 109

Expectations—Great and Otherwise, by C. Knight Aldrich, M.D., Chicago, Ill. ---- 114

Wilms' Tumor: Study of 29 Cases, by Marvin L. Hinke, M.D., and Halvor Vermund, M.D., Madison ---------- 119

Roentgen Diagnosis of Compartmental Disease of the Gallbladder, by I. Nik Nevin, M.D., Warner S. Bump, M.D., and Irving E. Schiek, Jr., M.D., Rhinelander -- 125

Clinicopathologic Conference, by Bernard Kalfayan, M.D., La Crosse ---------- 129

SPECIAL FEATURES

1963 SMS Annual Meeting Highlights ---- 6

Trichinosis—A Continuing Health Problem (abstract) ---------- 113

Tularemia in Wisconsin (abstract) ------ 118

Don't Overlook Phage Typing! (abstract) -- 128

Comments on Treatment: Angiotensin, by Albert C. Yard, M.D., Ph.D., Milwaukee ---------- 135

Page

Diabetic Nephropathy Without Manifest Diabetes (abstract) ---------- 136

Oral Hypoglycemic Agents in Diabetic Patients with Pulmonary Tuberculosis (abstract) ---------- 138

Staff of Aesculapius ---------- 140

Three Teaching Programs ---------- 64

EDITORIALS

President's Page: The Associated Professions, by N. A. Hill, M.D., Madison ---- 137

Confreres of the Cloth ---------- 139

REGULAR FEATURES

Facts About Wisconsin Physicians Service -- 34

County Society Proceedings ---------- 39

Specialty Society Proceedings ---------- 43

News of Wisconsin Physicians ---------- 45

Recent Wisconsin Licentiates ---------- 50

Calendar of Meetings ---------- 57

Medical Meetings—Postgraduate Courses -- 57

Physicians' Exchange ---------- 65

Index to Advertisers ---------- 68

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Journal
Established 1903

Annual Subscriptian-------$6.00
Single Copy---------- 1.00
Previaus Years'---------- 2.00

ADVERTISING REPRESENTATIVES: State Medical Jaurnal Advertising Bureau, Inc., 510 North Dearbarn Street, Chicaga 10, Illinais; and Business Management Services, Inc., Park Ridge, Stevens Point, Wiscansin.

Secand-class postage paid at Madisan, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at speciol rate of pastage provided for in Section 1103, Act of Octaber 3, 1917. Autharized August 7, 1918." Address all communicatians ta THE WISCONSIN MEDICAL JOURNAL. Street address: 303 East Lakeside Street. Mailing address: Box 1109, Madisan 1, Wiscansin.

1963 ANNUAL MEETING

Something Important for Every Physician

Working closely with the various specialty societies and the Wisconsin Academy of General Practice, the Commission on Scientific Medicine has prepared an outstanding program for the Annual Meeting in Milwaukee, May 6–7–8–9. To give you an opportunity of planning your attendance, the outline of the Scientific Program is included in the January and February issues of the JOURNAL. The March issue will include full details, and *around the latter part of March a special announcement on the noon scientific luncheons will be sent you.*

PLAN NOW TO ATTEND, AND MARK YOUR CALENDAR FOR THESE DATES

MONDAY, MAY 6; TUESDAY, MAY 7; AND WEDNESDAY, MAY 8

House of Delegates sessions

TUESDAY, MAY 7

1. Current Concepts of Arteriosclerosis and Hypertension

A. CURRENT PATHOPHYSIOLOGICAL CONCEPTS OF ARTERIOSCLEROSIS AND HYPERTENSION: Paul Kimmelsteil, M. D., Milwaukee

B. PITFALLS IN DRUG THERAPY: Charles W. Crumpton, M. D., Madison

C. THE PRESENT SURGICAL APPROACH: Ormand C. Julian, M. D., Chicago

2. Diabetes and Smoking as Special Problems in the Aged

A. MANAGEMENT OF THE ELDERLY DIABETIC: George Hamwi, M. D., Columbus, Ohio

B. SMOKING AS A SPECIAL PROBLEM IN THE AGED

Edward Cuyler Hammond, Sc.D., New York City

Ross C. Kory, M. D., Milwaukee

John R. Talbot, M. D., Madison

3. Noon Luncheons

Luncheons on internal medicine (Fredrick J. Stare, M. D., Boston), and many others will be presented. Full details on all scientific luncheon programs during the Annual Meeting will be publicized in the future. While certain of the luncheons serve as official luncheons for specialty organizations, they are open to all members of the State Medical Society so long as seating is available.

4. Nutritional Problems of the Aged

A. GENERAL PRINCIPLES, THE HAZARDS OF FADDISM AND QUACKERY, AND PRACTICAL POINTS: Fredrick J. Stare, M. D., Boston (Conrad A. Elvehjem Memorial Lecture)

B. DIET AND CARDIOVASCULAR DISEASE: J. Stamler, M. D., Chicago

C. DIET AND SERUM CHOLESTEROL IN THE AGED: William E. Connor, M. D., Iowa City

5. Osteoarthritis and Osteoporosis

A. CURRENT CONCEPTS OF OSTEOARTHRITIS AND OSTEOPOROSIS: Richard H. Ferguson, M. D., Rochester, Minnesota

6. Psychiatric Aspects of Aging

A. PSYCHIATRIC ASPECTS OF PREPARATION FOR DEATH: Elihu S. Howland, M. D., Chicago

B. THE MINISTER AND THE DOCTOR MEET: Granger E. Westberg, D. D., Chicago

WEDNESDAY, MAY 8

1. General Scientific Program

A. MOST RECENT DEVELOPMENTS IN CHEMOTHERAPY IN THE TREATMENT OF CARCINOMA (Panel) "Regional Chemotherapy for Cancer": (Speaker to be named) Discussants: A. R. Curreri, M.D., Madison, John Hurley, M. D., Milwaukee

B. FREQUENT EMOTIONAL CRISES OF PATIENTS AND THEIR FAMILIES: John Romano, M. D., Rochester, New York

C. THE ANTIBIOTIC THERAPY OF BACTERIAL ENDOCARDITIS: J. E. Geraci, M. D., Rochester, Minnesota

2. Noon Luncheons

Luncheons on radiology (speaker pending), fevers (J. E. Geraci, M. D., Rochester, Minn.), pathology (Frank J. Glassy, M. D., Sacramento, Calif.), obstetrics (Ben Peckham, M. D., Madison), psychiatry (John Romano, M. D., Rochester, N. Y.), cancer (speaker to be named) and electrocardiography (Richard H. Wasserburger, M. D., Madison).

3. Afternoon Scientific Programs

A. OBSTETRICS AND GYNECOLOGY

"Selection of Treatment of Gynecologic Malignancies", Clyde L. Randall, M. D., Buffalo, N.Y.

B. PATHOLOGY

"Collagen Disease and Immunity," Frank J. Glassy, M. D., Sacramento, Calif. Panel on Collagen Diseases: Charles Altshuler, M. D., Paul Kimmelstiel, M. D., and John Smith, M. D., all of Milwaukee

C. PSYCHIATRY

"The Psychiatric Referral and Other Aspects of Relationship Between the Psychiatrist

and the Referring Physician", John Romano, M. D., Rochester, N.Y.
"Specificity in Psychosomatic Disease", David T. Graham, M. D., Madison

D. RADIOLOGY
"Esophageal Hiatus Hernia", (speaker pending)
"Roentgenological Diagnosis of Intrathoracic Disease in the Newborn", Lawrence A. Davis, M. D., Louisville, Ky.

THURSDAY, MAY 9

1. Medical Aspects of Sports

A. KNEE INJURIES: Robert W. Bailey, M. D., Ann Arbor, Mich.

B. COMMON DERMATOLOGIC PROBLEMS ASSOCIATED WITH SPORTS AND HOW BEST TO MEET THEM: C. G. Mendelson, M. D., Detroit, Mich.

2. Noon Luncheons

Luncheons on anesthesiology (John J. Bonica, M. D., Seattle, Wash.), EENT, orthopedics (Robert W. Bailey, M. D., Ann Arbor, Mich.), public health (Peter C. Kronfeld, M. D., Chicago), dermatology (C. G. Mendelson, M. D., Detroit), pediatrics (Herbert A. Wenner, M. D., Kansas City, Ovid Meyer, M. D., Madison; and John Morrissey, M. D., Madison).

3. Afternoon Scientific Programs

A. ANESTHESIOLOGY
"Anesthesia for Infants," Robert M. Smith, M. D., Boston, Mass.
"Regional Anesthesia in Children", John J. Bonica, M. D., Seattle, Wash.
"Anesthesia for Poor Risk Pediatric Patients", Robert M. Smith, M. D., Boston, Mass.

B. OPHTHALMOLOGY AND OTOLARYNGOLOGY
"Current Trends in Otolaryngology," Lawrence R. Boies, M. D., Minneapolis, Minn.
"Recent Developments in Glaucoma Surgery," Peter C. Kronfeld, M. D., Chicago, Ill.

C. PEDIATRICS
"New Virus Diseases in Pediatrics". Herbert A. Wenner, M. D., Kansas City, Kansas
"Metabolic Disorders in Children", Harry A. Waisman, M. D., Madison
"Anesthesia for Poor Risk Pediatric Patients", Robert M. Smith, M. D., Boston, Mass.

D. SURGERY
"An Analysis of Fractures and Dislocations of the Spine", Robert W. Bailey, M. D., Ann Arbor, Mich.
"Portal Hypertension—Management of Bleeding and Ascites", Ivan D. Baronofsky, M. D., San Diego, Cal.

OUT-OF-STATE GUEST LECTURERS

Ormand C. Julian, M. D., Chicago
George Hamwi, M. D., Columbus, Ohio
E. Cuyler Hammond, Sc. D., New York City
Frederick J. Stare, M. D., Boston
J. Stamler, M. D., Chicago
William E. Connor, M. D., Iowa City
Richard H. Ferguson, M. D., Rochester, Minn.
Elihu S. Howland, M. D., Chicago
Clyde L. Randall, M. D., Buffalo, N.Y.
Peter C. Kronfeld, M. D., Chicago
Lawrence R. Boies, M. D., Minneapolis
C. G. Mendelson, M. D., Detroit
Herbert A. Wenner, M. D., Kansas City
Lawrence A. Davis, M. D., Louisville, Ky.
Robert M. Smith, M. D., Boston

MARQUETTE UNIVERSITY SCHOOL OF MEDICINE 50TH ANNIVERSARY

The Annual Meeting program this year will honor Marquette University School of Medicine on its Fiftieth Anniversary. Edward R. Annis, M. D., Miami, Florida, President-Elect of the American Medical Association, an alumnus of the school, will attend the meeting and six other alumni have been invited to be out-of-state guest lecturers in the scientific programs of the Annual Meeting.

ROBERT W. BAILEY, M. D.
(Class of 1946), Department of Orthopedic Surgery, University of Michigan Medical School, Ann Arbor, Mich.

IVAN D. BARONOFSKY, M. D.
(Class of 1943), Clinical Professor of Surgery, University of Southern California School of Medicine, San Diego, Calif.

JOHN J. BONICA, M. D.
(Class of 1942), Professor and Chairman, Department of Anesthesiology, University of Washington School of Medicine, Seattle, Wash.

J. E. GERACI, M. D.
(Class of 1942), Clinical Section, Mayo Clinic, Rochester, Minn.

FRANK J. GLASSY, M.D.
(Class of 1946), Dept. of Pathology, Sutter Community Hospitals, Sacramento, Calif.

JOHN ROMANO, M. D.
(Class of 1934), Professor of Psychiatry and Psychiatrist-In-Chief, Strong Memorial Hospital, University of Rochester School of Medicine, Rochester, N.Y.

EDWARD R. ANNIS, M. D.

SPECIAL ANNUAL MEETING FEATURE

Tuesday, May 7

A special conference sponsored by the Division on Aging of the State Medical Society, in cooperation with the Wisconsin Society of Internal Medicine and the Wisconsin Academy of General Practice.

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A FULL DAY'S PROGRAM

1. Current Concepts of Arteriosclerosis and Hypertension
2. Diabetes and Smoking as Special Problems in the Aged
3. Nutritional Problems of the Aged
4. Osteoarthritis and Osteoporosis
5. Psychiatric Aspects of Aging

SPEAKERS

PAUL KIMMELSTEIL, M.D., Milwaukee
Professor of Pathology
Marquette University School of Medicine

CHARLES W. CRUMPTON, M.D., Madison
Professor of Medicine
University of Wisconsin Medical School

ORMAND C. JULIAN, M.D., Chicago
Professor of Surgery
University of Illinois College of Medicine

GEORGE HAMWI, M.D., Columbus, Ohio
Professor of Medicine
Ohio State University Medical School

EDWARD CUYLER HAMMOND, Sc.D., New York City
Director, Statistical Research Section
American Cancer Society

ROSS C. KORY, M.D., Milwaukee
Associate Professor of Medicine
Marquette University School of Medicine

JOHN R. TALBOT, M.D., Madison
Associate Clinical Professor of Medicine
University of Wisconsin Medical School

FREDERICK J. STARE, M.D., Boston
Department of Nutrition, School of Public Health
Harvard University

JEREMIAH STAMLER, M.D., Chicago

WILLIAM E. CONNOR, M.D., Iowa City
Department of Medicine
State University of Iowa College of Medicine

RICHARD H. FERGUSON, M.D., Rochester, Minnesota
Clinical Section
Mayo Clinic

ELIHU S. HOWLAND, M.D., Chicago

GRANGER E. WESTBERG, D.D., Chicago

Doctors Hammond, Hamwi, Julian, Stare and Ferguson will all conduct luncheons. Watch your mail in March for the special announcement and reservation form.

FIRESIDE CONFERENCES

Tuesday, May 7—Hotel Schroeder

DINNER—6:30 p.m. CONFERENCE—8 p.m.

Sponsored by the Wisconsin Chapter of the American College of Chest Physicians

Eleven subjects will be discussed simultaneously at an equal number of tables in the Pere Marquette Room and East Room starting at 8 p.m. Physicians are welcome to table hop, listen or participate in the informal discussions. Refreshments will be served.

Subjects to be covered and the leaders of the discussions are as follows:

1. CORONARY DISEASE—discussion of problems in diagnosis, management, and complications thereof.
   Howard Correll, M.D., Milwaukee; *Julius Meyer*, M.D., Milwaukee; *Herman Shapiro*, M.D., Madison.
2. CARDIAC SURGERY—with emphasis on selection of cases.
   Vincent Gott, M.D., Madison; *Derward Lepley*, Jr., M.D., Milwaukee; *William Young*, M.D., Madison; *Armin Baier*, M.D., Milwaukee.
3. ELECTROCARDIOGRAMS—what they tell us; what they do not.
   D. J. Nuyda, M.D., Milwaukee; *Francis Rosenbaum*, M.D., Milwaukee; *Richard Wasserburger*, M.D., Madison.
4. ACUTE RHEUMATIC FEVER—a discussion of diagnosis and management.
   William J. Gallen, M.D., Milwaukee; *Gerson Bernhardt*, M.D., Milwaukee.
5. CLINICAL CARDIOLOGY—with special attention to problems in:
   Stethoscopic and physical examination of the heart
   John Huston, M.D., Milwaukee.
   Differential diagnosis of chest pain—cardiac or non-cardiac
   George Hellmuth, M.D., Milwaukee.
   Treatment of Cardiac failure
   Mischa Lustok, M.D., Milwaukee.
6. CHRONIC LUNG DISEASE—diagnosis and problems in management with attention primarily on 'chronic bronchitis', bronchiectasis, pneumoconioses, and chronic pulmonary emphysema.
   Leon Hirsh, M.D., Milwaukee; *Ross Kory*, M.D., Milwaukee; *Avrum Organick*, M.D., Milwaukee; *John Rankin*, M.D., Madison.
7. BRONCHIAL ASTHMA—a discussion of problems in management.
   John Arkins, M.D., Milwaukee; *Abe Sosman*, M.D., Milwaukee; *John Talbot*, M.D., Madison.
8. CHEST X-RAYS—problems in interpretation and pitfalls in reading.
   John Amberg, M.D., Milwaukee; *Donald Babbitt*, M.D., Milwaukee; *Jerome Marks*, M.D., Milwaukee.
9. PULMONARY FUNCTION STUDIES—their value, problems in interpretation, and techniques.
   J. Bernard Gee, M.D., Madison; *David Rosenzweig*, M.D., Milwaukee; *Walter Thiede*, M.D., Milwaukee.
10. PULMONARY TUBERCULOSIS AND FUNGUS DISEASES—a discussion of the recent advances in diagnosis and treatment thereof.
    Helen Dickie, M.D., Madison; *William Stead*, M.D., Milwaukee.
11. LUNG CANCER—the problem discussed from the standpoint of diagnosis, prevention, and treatment.
    Fred J. Ansfield, M.D., Madison; *Anthony Curreri*, M.D., Madison; *John R. Pellett*, M.D., Madison; *Albert Pemberton*, M.D., Milwaukee.

A Special Annual Meeting Feature

MEDICAL ART SALON

SPONSOR: The Woman's Auxiliary to the State Medical Society of Wisconsin

CO-CHAIRMEN: Dr. and Mrs. Harry Foerster, Jr.,, and Dr. and Mrs. William F. Hovis, Jr., Milwaukee

MILWAUKEE AUDITORIUM . . . MAY 6–9, 1963

Sculptures and Paintings (watercolors and oils only)

WHO MAY EXHIBIT: Any member of the State Medical Society of Wisconsin or his **wife.**

LIMITED ENTRIES: Up to 3 entries per person.

DEADLINE FOR ENTRIES: All notifications of "Intent to Exhibit" must be in the hands of Dr. and Mrs. Harry Foerster, Jr., Milwaukee, on or before April 1, 1963. (Early notification will be appreciated, so that proper facilities for the entire exhibit can be planned in advance. Mail your entry blank below as soon as possible.)

REQUIREMENTS: (1) All pictures must be framed with wire and screw eyes attached. (2) Works of sculpture must not exceed 24 inches in height. (3) All entries must be delivered to the Dressing Room on the east side of the stage of Bruce Hall, Milwaukee Auditorium between 8:00 a.m. and 10:00 a.m., Monday, May 6, and must be picked up in the display area between 3:30 p.m. and 5:00 p.m., Thursday, May 9.

JUDGING AND AWARDS: Ribbons for first, second, and third places in each of the three categories (sculpture, watercolor painting, oil painting) will be awarded, plus a "popularity award" based on votes of all those who view the Art Salon.

LIMITED LIABILITY: The submitter must assume full responsibility for work submitted, but every care against damage or theft will be exercised. Guard will be provided during the course of the display.

NOTIFICATION OF INTENT TO EXHIBIT

Mail to Dr. and Mrs. Harry Foerster, Jr., 4830 N. Oakland Ave., Milwaukee 17, Wis., BEFORE APRIL 1, 1963.

I plan to submit the following entry or entries for the 1963 MEDICAL ART SALON at the Milwaukee Auditorium, May 6–9.

My entry, or entries, will be:

(1) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(2) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(3) Painting ____ Title _____ ☐ watercolor ☐ oil size _____" wide and _____" deep

(1) Sculpture __ Title _____ size _____" wide and _____" high

(2) Sculpture __ Title _____ size _____" wide and _____" high

(3) Sculpture __ Title _____ size _____" wide and _____" high

Name: _____ Street: _____

City: _____

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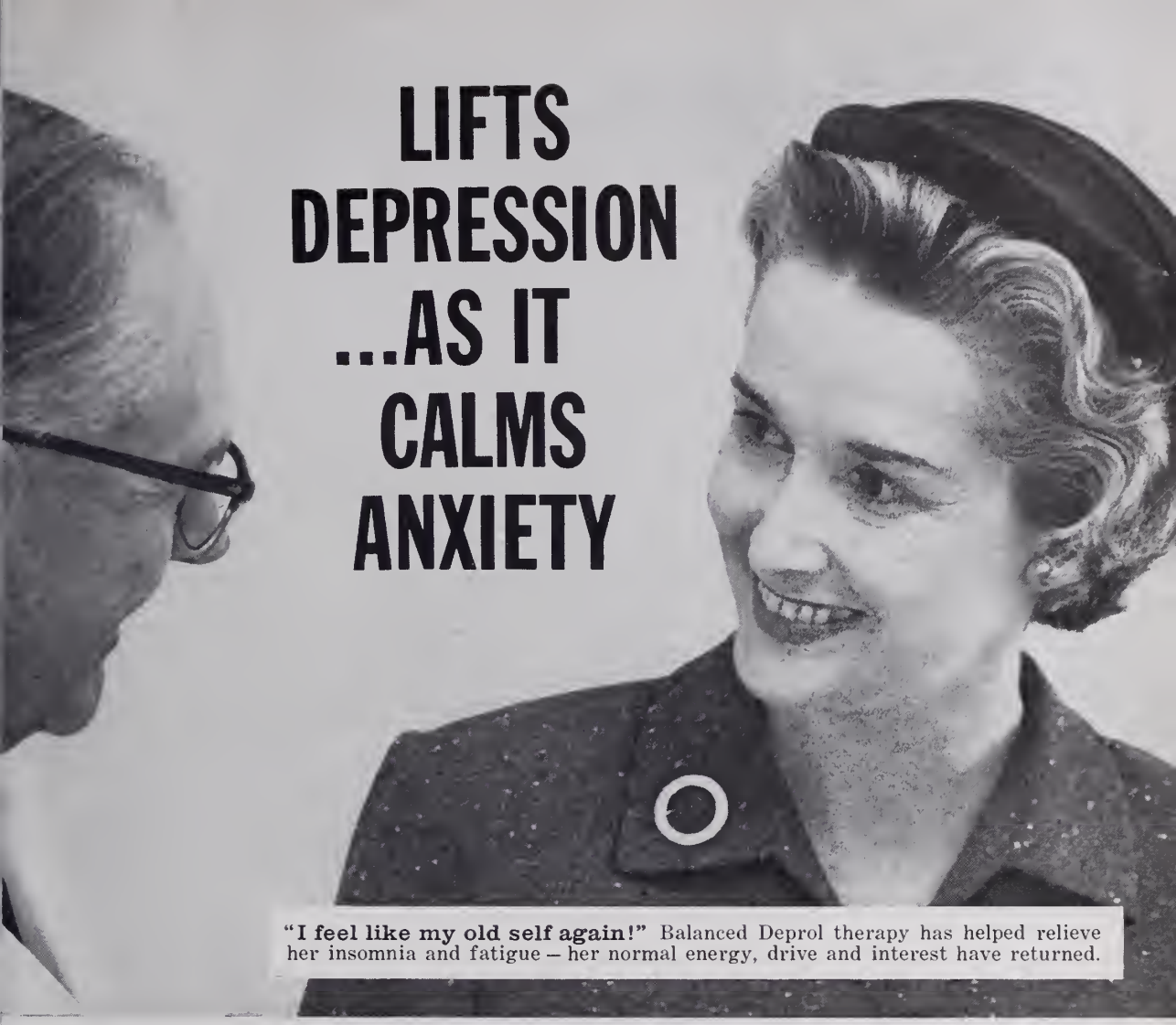

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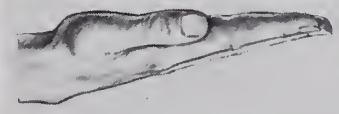

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Facts about

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON MEDICAL CARE PLANS

The following excerpts are taken from Mr. H. L. Toser's presentation on the WPS Special Service contract recently made before members of the Montgomery County Medical Society, Dayton, Ohio.

SPECIAL SERVICE MEDICAL CARE CONTRACT

"As we see it, the role of the National Association of Blue Shield Plans is largely one of coordination. By contrast, the principal objective of member plans, under a recognized system of autonomy at the local or state level, is to remain *continuously* alert to the medical and surgical insurance needs of the public in the respective areas they serve.

"It is 30 years ago since action was first taken by the American Medical Association to guide and direct the development of nonprofit medical prepayment programs. And it was this same interest and action which led to the establishment of the National Association of Blue Shield Plans.

"With this historical background in mind, the State Medical Society of Wisconsin set about in 1955 to study the possibility of introducing through its insurance division, Wisconsin Physicians Service, a mechanism which would undertake to pay physicians' charges on other than a scheduled basis. It recognized at the same time the need for a practical substitute for the usual fee schedule . . . one which would be fair to all concerned, the vendor of services included, with elements of "control" designed to keep the cost of such broader benefits at a level which would make their purchase financially attractive.

"It is the conviction of Wisconsin Physicians Service that the 'No Fee Schedule' concept of voluntary, nonprofit surgical-medical insurance is entirely practicable, completely workable, and generally more satisfactory to patients and physicians alike than any other form of health insurance benefit with which it is familiar.

"While making no claim that its own favorable experience in this field will be met or exceeded elsewhere, WPS does not see in this concept any dangers not already recognized. On the contrary, it believes most sincerely that the 'No Fee Schedule' principle can safely be applied to other categories of health insurance in much the same manner that it has been employed in other forms of insurance over a period of many years."

THE DOCTORS' PLAN OF THE STATE MEDICAL SOCIETY

WPS SURGICAL MEDICAL HOSPITAL

WISCONSIN PHYSICIANS SERVICE

330 E LAKESIDE MADISON 1, WISCONSIN ALPINE 6-3101

County Society Proceedings

BROWN

Dr. J. L. Sims, Madison, professor of medicine at the University of Wisconsin Medical School, addressed the Brown County Medical Society on "The Malabsorption Syndrome" January 10 at Green Bay.

New officers of the Society elected at their December 13, 1962 meeting include:

President: *Dr. John E. Dettmann*, Green Bay
President-elect: *Dr. L. H. Edelblute*, Green Bay
Secretary-Treasurer: *Dr. Frank Urban*, Green Bay
Delegate: *Dr. B. P. Waldkirch*, De Pere
Alternate: *Dr. Donel Sullivan*, Green Bay
Censor: *Dr. R. G. Wochos*, Green Bay

CHIPPEWA

The Chippewa County Medical Society elected the following officers for 1963 at its December meeting:

President: *Dr. George C. Shonat*, Chippewa Falls
Vice-president: *Dr. Charles A. Kemper*, Chippewa Falls
Secretary: *Dr. Clifford T. Bowe*, Cadott
Delegate: *Dr. Merne W. Asplund*, Bloomer
Alternate: *Dr. John J. Sazama*, Chippewa Falls

DANE

"Medical Care for the Aged" was the subject of a panel discussion moderated by *Dr. Robert Samp*, Madison, at the January 8 meeting of the Dane County Medical Society at Madison. Participants included: *Drs. John Salick, Addie Schwittay, Jay Keepman, Robert Beilman, J. Richard Johnson* and *James Wilkie*, all of Madison.

John P. Reynolds, Madison, vice-president of field services for Wisconsin Taxpayers Alliance, an independent, nonpartisan governmental research organization, discussed the state tax situation at the Society's December meeting.

DODGE

The December meeting of the Beaver Dam Medical Forum was held at the home of *Dr. Darrell Link*. *Dr. Roger Bender*, Beaver Dam, spoke on "Geriatric Problems—Preoperative, Surgical and Postoperative."

Dr. G. G. Drescher, Beaver Dam, spoke on "Reiter's Syndrome" at the November meeting of the Forum held at the home of *Dr. Howard Bayley*.

DOUGLAS

Members of the Douglas County Medical Society heard *Dr. Fred J. Ansfield*, Madison, speak on "Chemotherapy of Solid Tumors" at their November meeting in Superior. Doctor Ansfield's appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Wisconsin Division of the American Cancer Society.

Physicians whose names appear in italic are members of the State Medical Society.

Dr. E. J. Nordby, third district councilor, accepted a portrait of *Dr. N. A. Hill*, president of the State Medical Society, which was presented to the Society by the Woman's Auxiliary to the Dane County Medical Society. The portrait has been hung in the lobby at Society headquarters along with portraits of other Dane county members who have served as president of the State Medical Society.

Mrs. Luther Holmgren, president of the Auxiliary to the Dane County Medical Society, made the presentation when the women's group met in the Presidents' Room at Society headquarters on January 8.

EAU CLAIRE–DUNN–PEPIN

Officers of the Eau Claire–Dunn–Pepin County Medical Society for 1963 are:

President: *Dr. R. R. Richards*, Eau Claire
Vice-president: *Dr. O. G. Moland*, Augusta
Secretary–Treasurer: *Dr. W. H. Walter*, Eau Claire
Delegates: *Dr. D. R. Griffith*, Eau Claire; *Dr. A. A. Drescher*, Menomonie
Alternates: *Dr. G. G. Giffen*, Eau Claire; *Dr. W. A. Manz*, Eau Claire

GRANT

The Grant County Medical Society met in Lancaster in November to elect officers for 1963. The Society also voted to proceed with a Sabin Oral Vaccine program after the first of the year.

New officers are:

President: *Dr. Charles Steidinger*, Platteville
Vice-president: *Dr. C. E. Mueller*, Boscobel

Secretary–Treasurer: *Dr. H. W. Carey*, Lancaster
Delegate: Doctor Carey
Alternate: Doctor Steidinger

GREEN

Five Monroe physicians are the newly elected officers of the Green County Medical Society. They are:

President: *Dr. Wayne J. Fencil*
Vice-president: *Dr. John Irvin*
Secretary–Treasurer: *Dr. B. H. Brunkow*
Delegate: *Dr. R. G. Zach*
Alternate: *Dr. W. J. Staab*

The Green County Medical Society sponsored a county-wide tetanus immunization program for all persons over the age of 12 late in November.

GREEN LAKE–WAUSHARA

Dr. William Wolberg, Madison, spoke on the choice and use of chemotherapy on carcinomas of the large colon at the last 1962 meeting of the Green Lake–Waushara County Medical Society held at Berlin. Officers elected for 1963 are:

President: *Dr. Grant Stone*, Berlin
Vice-president: *Dr. Leonard Shemanski*, Wautoma
Secretary–Treasurer: *Dr. Lynn J. Seward*, Berlin
Delegate: *Dr. C. A. Klasinski*, Wautoma
Alternate: *Dr. David Sievers*, Berlin

JEFFERSON

Newly elected officers of the Jefferson County Medical Society are:

President: *Dr. E. Allen Miller*, Watertown
Vice-president: *Dr. J. J. Harris*, Fort Atkinson
Secretary: *Dr. John S. Garman*, Waterloo
Delegate: *Dr. Joseph J. Voytek*, Fort Atkinson
Alternate: *Dr. Roland R. Liebenow*, Lake Mills

KENOSHA

The Kenosha County Medical Society has elected the following officers, all from Kenosha to serve for 1963:

President: *Dr. James J. Lutz*
President-elect: *Dr. Chester A. Sattler*
Secretary–Treasurer: *Dr. Gene F. Armstrong*
Delegate: *Dr. Richard W. Ashley*
Alternate: *Dr. George C. Schulte*

The Society also voted to proceed with a community-wide immunization program using all three types of Sabin oral vaccine against poliomyelitis. The first "Oral Sunday" is scheduled for March 17.

LA CROSSE

Dr. Anthony Pisciotta, Milwaukee, spoke on "General Aspects of Anemia" at the December meeting of the La Crosse County Medical Society. The following officers, all of La Crosse, were elected for 1963:

Vice-president: *Dr. Frederick H. Wolf*
Secretary–Treasurer: *Dr. Ruth M. Dalton*
Delegate: *Dr. George B. Murphy, Jr.*

MARATHON

The following officers and committee chairmen have been elected to serve the Marathon County Medical Society for 1963:

President-elect: *Dr. G. R. Hammes*, Wausau
Secretary: *Dr. George Kordiyak*, Wausau
Program chairman: *Dr. R. M. Kass*, Wausau
Board of Censors chairman: *Dr. E. P. Ludwig*, Wausau
Public Health and Legislature chairman: *Dr. W. B. Rudy*, Wausau
Insurance, Medical Economics and Grievance chairman: *Dr. W. H. Knoedler*, Mosinee
Public Relations chairman: *Dr. W. C. Miller*, Wausau

MILWAUKEE

Dr. Jonathan E. Rhoads, Philadelphia, spoke on the "Surgical Treatment of Cancer of the Pancreatico–Duodenal Region" at the January 17 meeting of The Medical Society of Milwaukee County held at the Wisconsin Club January 17. Doctor Rhoads is the John Rhea Barton Professor of Surgery at the University of Pennsylvania. During his stay in Milwaukee, he served as the third annual Carl Eberbach Visiting Professor of Surgery at the Marquette University School of Medicine.

At the December 13 meeting of the Society, the 1963 president was installed and the report of the nominating committee was formally accepted as follows:

President: *Dr. Robert A. Frisch*, Shorewood
President-elect: *Dr. Robert S. Haukohl*, Brookfield
Secretary: *Dr. William C. Curtis*, Elm Grove
Treasurer: *Dr. Frank E. Drew*, Milwaukee
Delegates: *Drs. Robert F. Purtell, Edward D. Wilkinson, Stanley E. Zawodny, Edgar End, Fordyce A. Ross, V. LaMar Baker*, Wauwatosa; *Anthony J. Sanfelippo* and *Leo R. Weinshel*, Whitefish Bay; *George S. Kilkenny, C. Morrison Schroeder* and *Howard M. Klopf*, Milwaukee
Alternates: *Drs. Roger Laubenheimer*, Shorewood; *Rex Ruppa* and *John R. Evrard*, Fox Point; *James R. O'Connell, Kendall E. Sauter*, and *Bruno J. Peters*, Wauwatosa; *George W. Dean, Thomas J. Cox*, and *Ralph Sproule*, Whitefish Bay; *Reuben J. Smartemo, Walter S. Polacheck*, and *John Bareta*, Milwaukee.
Committee on Credentials: Drs. Sauter and *John J. Smith*, Shorewood
Board of Directors: *Dr. Roman E. Galisinski*, Milwaukee

OUTAGAMIE

New officers of the Outagamie County Medical Society, all of Appleton, are:

President: *Dr. Francis M. Hauch*
Vice-president: *Dr. Jack Anderson*
Secretary: *Dr. William Chandler*

Appleton Post–Crescent Photo

New officers of the Outagamie County Medical Society are, from left to right: Dr. William Chandler, secretary; Dr. Jack Andersan, vice-president; and Dr. Francis M. Hauch, president.

OZAUKEE

Dr. J. J. Gramling, Jr., and *Dr. Alan B. Fidler*, both of Milwaukee, spoke on cancer and its treatment by chemotherapy at the November meeting of the Ozaukee County Medical Society held at Port Washington. Their appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Wisconsin Division of the American Cancer Society.

Dr. R. F. Henkle and *Dr. P. W. Wallestad*, both of Port Washington, are the new president and secretary respectively of the Society.

PORTAGE

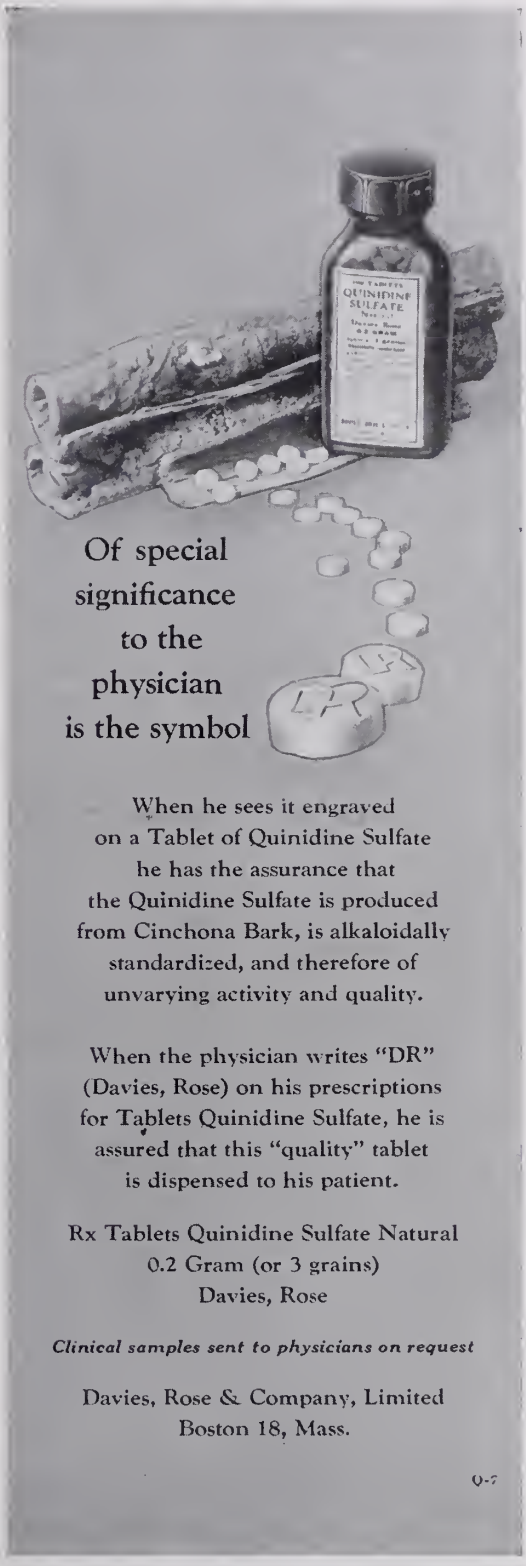
Dr. F. D. Bernard, Madison, presented a paper on "The Treatment of Facial Injuries" before the Portage County Medical Society meeting at Stevens Point in November. *Drs. F. C. Iber* and *F. W. Reichardt*, both of Stevens Point, were the discussants.

Doctor Bernard's appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Merck Sharp & Dohme Postgraduate Program.

RACINE

Racine physicians who are serving the Racine County Medical Society as officers for 1963 are:

President: *Dr. Warren H. Williamson*
President-elect: *Dr. E. L. MacVicar*
Vice-president: *Dr. F. J. Scheible*



Secretary: *Dr. L. E. Jones*
Treasurer: *Dr. R. J. Mayer*

The Society, together with several local agencies, will sponsor a large-scale diabetes detection survey February 4 through April 5.

RICHLAND

The Richland County Medical Society met in Richland Center in December and elected the following officers, all of Richland Center for 1963:

President: *Dr. Richard W. Edwards*
Vice-president: *Dr. R. G. Hansel*
Secretary–Treasurer: *Dr. L. M. Pippin*
Censor: *Dr. R. C. Glise*
Delegate: *Dr. D. J. Taft*
Alternate: *Dr. R. E. Housner*

Dr. William H. Wolberg, Madison, spoke on "Colon Cancer" at the November meeting of the Society. His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Wisconsin Division of the American Cancer Society.

TREMPEALEAU–JACKSON–BUFFALO

Dr. William Gallagher of La Crosse showed slides and discussed his Peruvian tour with the hospital ship HOPE at the November meeting of the Trempealeau–Jackson–Buffalo County Medical Society at St. Joseph's Hospital in Arcadia. Officers for 1963 elected at the meeting include:

President: *Dr. Richard Holder*, Black River Falls
President-elect: *Dr. Albert Daniells*, Arcadia
Secretary–Treasurer: *Dr. John H. Noble*, Black River Falls
Public Relations Officer: *Dr. O. M. Schneider*, Blair
Delegate: *Dr. Elmer Rohde*, Galesville
Alternate: *Dr. William Wright*, Mondovi

WAUPACA

Dr. W. J. Egan, Milwaukee, president-elect of the State Medical Society, was the featured speaker at the annual meeting of the Waupaca County Medical Society held at the Waupaca Country Club in November.

WOOD

The Wood County Medical Society met at Wisconsin Rapids in December to elect the following officers for 1963:

President: *Dr. F. G. Gouze*, Marshfield
Vice-president: *Dr. C. J. Ryan*, Arpin
Secretary: *Dr. J. W. Rupel*, Marshfield

Following the business meeting, the group toured the plant of Consolidated Papers in Wisconsin Rapids.

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Specialty Society Proceedings

American Cancer Society

Kenosho County Unit

Dr. Stephen Holt, Kenosha, was elected president at a recent meeting of the Kenosha County unit of the American Cancer Society held at Kenosha. *Dr. Harry Schwartz*, Kenosha, service chairman, and *Dr. V. M. Miller*, Racine, education chairman, presented reports.

Wisconsin Psychiatric Association

More than 50 persons attended the annual scientific meeting sponsored by the Southern Chapter of the Wisconsin Psychiatric Association at Madison December 8. Among those participating in a panel discussion were *Dr. Henry Everett*, Madison, and *Dr. Jack Edson*, Waukesha.

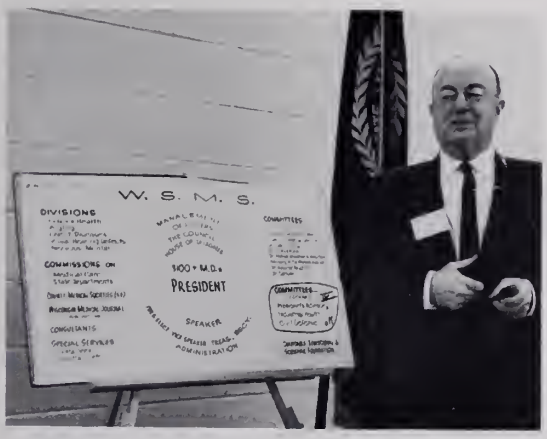
Milwaukee Oto-Ophthalmic Society

Dr. Alson E. Braley, professor and head of the department of ophthalmology, University of Iowa, spoke on "Virus Diseases of the Eye" at the January 22 meeting of the Milwaukee Oto-Ophthalmic Society at the University Club of Milwaukee.

State Medical Society Sections

Dr. R. E. Callan, Milwaukee, and *Dr. H. W. Carey*, Lancaster, speaker and vice-speaker respectively of the House of Delegates of the State Medical Society of Wisconsin, presided at the conference for officers, delegates and alternate delegates of sections of the State Medical Society held at the Society headquarters in Madison January 12.

Dr. W. J. Egan, Milwaukee, president-elect of the State Medical Society, opened the conference with a special presentation explaining the sections entitled "A United Profession." Doctor Callan continued the background presentation with "The 'Sections' and How They Grew."



Dr. W. J. Egan presented "A United Profession" at the meeting of SMS sections January 12.

Program participants at the January 12 meeting of SMS sections included, left to right, Dr. James V. Bolger, Jr., Waukesha; Dr. Robert S. Gearhart, Madison; Dr. John R. Evrard, Milwaukee; Dr. H. W. Carey, Lancaster; Dr. Robert E. Collan, Milwaukee.

Dr. Robert S. Gearhart, Madison, chairman of the Commission on Hospital Relations and Medical Education of the State Medical Society, spoke on medicine's interest in nursing; *Dr. John R. Evrard*, Milwaukee, chairman of the Division on Maternal and Child Welfare, State Medical Society, spoke on research; and *Dr. James V. Bolger, Jr.*, Waukesha, discussed medicine's interest in optometry and opticianry

Mr. R. B. Murphy, Madison, legal counsel for the State Medical Society, presented a preview of the 1963 state legislature.

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News of Wisconsin Physicians

Dr. Cejpek Elected Pediatrics Fellow

Dr. Karel O. Cejpek, La Crosse, has been elected a fellow of the American Academy of Pediatrics.

Marquette Honors Wisconsin Physicians

Marquette University School of Medicine has honored 223 physicians for their generous financial contributions toward the school's progress by inscribing their names permanently on a special plaque in the medical school. Among the Wisconsin physicians whose names appear on the plaque are: *Drs. Ralph B. Lenz,* De Pere; *William P. Hamilton,* Dodgeville; *John K. Karsten,* Horicon; *Henry E. Majeski,* Luxemburg; *John D. Wilkinson, John J. O'Hara,* and *John P. Kelly,* Pewaukee; *Charles P. Kauth,* Port Washington; *Robert H. Dorr,* Belgium; *Russell Kurten* and *William E. Buckley,* Racine; *Joseph A. Russell,* Random Lake; *J. H. Houghton* and *Frederick V. Gissal,* Wisconsin Dells; *Raymond O. Frankow,* West Bend.

Dr. Pfeifer Continues His Practice

Dr. F. J. Pfeifer, New London physician for more than 50 years, celebrated his 83rd birthday in November by spending a normal day in practice at his office. Doctor Pfeifer earned his way and graduated from the University of Wisconsin and the college now known as Marquette University. He converted his home into a hospital for 20 years and was instrumental in getting a 50-bed Community Hospital built in 1931. He helped organize the New London Rotary Club, the golf club and the Wolf River Retriever Club.

Dr. Michael Certified by Board

Dr. James D. Michael, Sheboygan, has been certified by the American Board of Internal Medicine. An internist with the Sheboygan Clinic since 1960, Doctor Michael attended Washington University, St. Louis, Mo., and received his medical degree from the university's School of Medicine in 1953. His internship was completed at Barnes Hospital in St. Louis in 1954. After serving a two-year tour of duty with the U. S. Air Force Medical Corps, he completed four years of residency training at Cincinnati General Hospital in Ohio.

Dr. Winter Honored by County Society

Dr. Bruce C. Winter, Union Grove, who headed the Racine County Medical Society's committee to organize Sabin Oral Sundays throughout Racine county, was presented a plaque which paid tribute to him for "unselfishly giving of his time and personal skills to the welfare of the community." *Dr. Warren H. Williamson,* newly-installed president of the Society, and *Dr. Frank M. Hilpert,* outgoing president, appeared with him at the presentation ceremony early in December.

Physicians whose names appear in italics are members of the State Medical Society.

Racine Journal-Times Photo

Dr. Bruce C. Winter

Dr. Warren H. Williamson Dr. Frank M. Hilpert

Dr. O'Connor Talks to Baraboo PTA Groups

Dr. R. E. O'Connor, Madison, child psychiatrist and superintendent of the Wisconsin Diagnostic Center, discussed "Behavior Growth of the Elementary School Child" before more than 200 persons at a joint meeting of the Baraboo PTA groups recently.

Wisconsin Medical Alumni at Meeting

Dr. Ben Lawton, Marshfield, headed a delegation of physicians who attended the annual fall meeting of the University of Wisconsin Medical Alumni Association in November. Doctor Lawton, who is president of the group, presided at the business meeting.

Participating in the scientific program, for which more than 150 physicians were registered, were the following members of the University of Wisconsin medical faculty: *Dr. Edgar S. Gordon,* professor of medicine; *Dr. Anthony R. Curreri,* professor of surgery; and *Dr. Alfred S. Evans,* director of the State Laboratory of Hygiene and professor and chairman of the department of preventive medicine. *Dr. Frank Weston,* clinical professor, was program chairman.

Dr. Hanson Is Chief of Hospital Staff

Dr. O. H. Hanson, Fort Atkinson, is the new chief of the medical staff at the Fort Atkinson Memorial Hospital. He succeeds *Dr. R. W. Quandt,* Jefferson.

Also named to staff positions are *Dr. Stephen Ambrose,* Whitewater, vice-chief of staff and *Dr. C. E.*

Quandt, Jefferson, secretary. Departmental heads include *Dr. Louis Gueldner*, Fort Atkinson, surgery; *Dr. George Nemec*, Cambridge, medical; and *Dr. James C. H. Russell*, Fort Atkinson, obstetrics.

Dr. Samp Addresses Nurses

Dr. Robert J. Samp, Madison, University Hospitals, spoke at a dinner meeting of the Appleton District of the Wisconsin Nurses Association at New London in November. Doctor Samp is medical director of the Wisconsin Division of the American Cancer Society and clinical cancer coordinator at the University of Wisconsin Medical Center.

Dr. Wright Discusses Paper

Dr. Marvin Wright of the Bump Medical Group at Rhinelander was one of three out-of-state physicians invited to discuss papers at the annual meeting of the Nebraska State Obstetric and Gynecologic Society in December. Doctor Wright discussed a paper by Dr. C. A. McWhorter of Omaha, Neb., on "An Evaluation of Cervical Cytology."

Monroe Physicians Receive Board Certificate

Dr. James R. Stormont, Dr. William J. Staab, Jr., and *Dr. Lewis F. Scribner*, all of the Monroe Clinic, have been certified by the American Board of Internal Medicine.

Hospital Staff Reelects Dr. Fink

Dr. R. J. Fink, Eau Claire, has been reelected president of the medical staff of Sacred Heart Hospital at Eau Claire. *Dr. T. E. Kilkenny* and *Dr. G. D. McAfee*, both of Eau Claire, were named vice-president and secretary-treasurer, respectively.

Others named were *Dr. A. J. Kelin*, Eau Claire, chief of services of the medical staff; *Dr. Karl Walter*, Eau Claire, chief of services of the obstetrics and gynecology departments; and *Dr. K. L. German*, Eau Claire, chief of services for surgery.

Dr. Loftus Receives Army Promotion

Dr. Edward B. Loftus, Winnebago, commanding officer of the Menasha section of the 44th General Hospital, has been promoted from major to lieutenant colonel. In civilian life Lt. Col. Loftus is a physician at the Winnebago State Hospital.

Sheboygan Physicians Attend Meetings

Dr. J. F. Hildebrand, Sheboygan, attended the American Academy of Dermatology in Chicago early in December.

Dr. J. W. McRoberts, Sheboygan, attended the annual meeting of the Western Surgical Society at St. Louis, Mo., in December.

Dr. Knutson Honored for 50 Years' Service

Some 300 friends toasted with tears and laughter *Dr. Oscar Knutson*, 80, at a lutefisk and lefse dinner at Osseo recently. In appreciation of his 50 years of medical service to the community, Doctor Knutson received a plaque.

Eau Claire Leader Photo

For his 50 years of medical service to the community, Dr. Oscar Knutson, center, was honored at a dinner at which Trempealeau County Judge A. L. Twesme, Whitehall, right, was master of ceremonies and Ervin Olson, president of the Osseo Commercial Club, left, presented him with a plaque of tribute.

Dr. Ashby Tells of Lithuania

Dr. A. O. Ashby, Sheboygan, was the principal speaker at the December meeting of the Sheboygan Chapter of the National Council of Presbyterian Men. He related some of his experiences in his native Lithuania, in Russia and in Finland during the time the Soviets took over the country.

Dr. Bowe Continues as Coroner

Dr. Clifford Bowe, Cadott, and *Dr. C. A. Kemper*, Chippewa Falls, provided a lively campaign for coroner of Chippewa County last fall with Doctor Bowe emerging victorious by just four votes.

Dr. Wright Serves on Hospital Board

Dr. Frank Wright, Appleton, is serving as a member of the temporary board of trustees for the Outagamie County Hospital.

Dr. March Talks to World War I Barracks

Dr. J. F. March, Algoma, spoke on coronary disease at a November meeting of World War I Barracks at Algoma. Doctor March is a member of the American Academy of Cardiology.

Dr. Woloschek Talks on Burns

Dr. W. J. Woloschek, Milwaukee, spoke on modern treatment of burns at a meeting sponsored by the Ashippun fire department at Oconomowoc late in November. Doctor Woloschek is on the staff of St. Mary's Hospital Burn Center in Milwaukee.

Dr. Cerny Talks on African Trip

Dr. Frank Cerny and Mrs. Cerny showed slides and discussed their recent African trip at a recent meeting of the Fond du Lac Medical and Dental Assistants Association at Fond du Lac.

Dr. Steussy Elected to High Masonic Post

Dr. M. W. Stuessy, Brodhead, has been elected worshipful master of Bicknell Masonic lodge in Brodhead. He was installed on December 27.

Dr. Engel Discusses Weather and Health

"Weather—How It Affects Health" was the subject on which *Dr. A. C. Engel*, New Holstein, addressed the Tuesday Club of New Holstein recently.

Dr. Hill Named Heart Campaign Sponsor

Dr. Nels A. Hill, president of the State Medical Society, is one of the 27 sponsors of the State Heart Association's 1963 Heart Fund Campaign.

Dr. Dekker Heads Hospital Staff

Dr. Cornelis Dekker, Genoa City, succeeds *Dr. L. O. Mastalir*, Burlington, as chief of the medical staff of Memorial Hospital at Burlington.

Dr. Cant Joins Clinic at Madison

Dr. Wilbur Cant has joined the pediatrics department of the Quisling Clinic at Madison. He transferred to Madison from Milwaukee Children's Hospital.

After being graduated from St. Ambrose College, Davenport, Ia., Doctor Cant received his M. D. degree from the University of Illinois College of Medicine. He interned for a year at San Diego County General Hospital and spent two years in the Air Force Medical Corps.

Dr. Burkholder Joins Menomonie Clinic

Dr. Dayton D. Burkholder, a native of North Dakota, has joined the staff of the Menomonie Clinic at Menomonie. He received his B. A. and B. S. degrees from the University at North Dakota and his M. D. degree from the University of Pennsylvania School of Medicine. Following internship at Ancker Hospital, St. Paul, Minn., and two years in the U. S. Air Force Medical Corps, he became associated with the DePuy Sorkness Clinic in Jamestown, N. D.

Dr. Mataczynski Named Medical Director

Dr. R. R. Mataczynski, Superior, has been named medical director of the Douglas County Hospital at Wentworth. Associated with the Giesen Clinic, Doctor Mataczynski has been attending physician at the institution.

Dr. Russell to Fill Unexpired Term

Dr. W. T. Russell, Sun Prairie, has been appointed to fill an unexpired term ending in 1966 on the State Medical Society's Commission on Public Policy.

Dr. Morrissey Returns to Madison

Dr. John F. Morrissey has returned to Madison and is now an assistant professor in the department of medicine at University Hospitals. His special field is gastroenterology. Doctor Morrissey practiced general internal medicine at the VA Hospital in Madison for four years before moving to Seattle where he remained for two years in the department of medicine at the University of Washington. He returned to Madison from Washington in July 1962.

Dr. Bonner Honored for Service

Dr. Joseph Bonner, Appleton, retiring president of the Outagamie County Medical Society, was given a plaque in recognition of his service to the Society at a recent meeting. *Dr. Francis Hauch*, Appleton, new president, made the presentation.

Dr. Morton Accepts Post in Bierut

Dr. S. A. Morton, president of The Medical Society of Milwaukee County in 1958, has begun a

Appleton Post–Crescent Photo

Joseph Banner, M. D. Francis Hauch, M. D.

three-year appointment as professor and chairman of the department of radiology at the American University of Bierut, Lebanon. He is on leave of absence as clinical professor of radiology at the Marquette University School of Medicine. He will continue to serve on the staff of Columbia Hospital, Milwaukee, as a consultant in radiology.

Dr. Egan Reappointed to Safety Commnssion

Dr. William J. Egan, Milwaukee, president-elect of the State Medical Society, has been reappointed to the Milwaukee Safety Commission. Originally appointed to the commission in 1955, he has been serving as secretary of the group and chairman of its Home Safety Committee.

Fond du Lac Otolaryngologists Certified

Darius Shahrokh, M. D.

Two Fond du Lac physicians recently were elected diplomates of the American Board of Otolaryngology. They are *Dr. Darius Shahrokh* and *Dr. James Hitselberger.*

Doctor Shahrokh received his medical training at the Mayo Clinic in Rochester, Minn., and recently received a master of science degree in otolaryngology from the University of Minnesota. An abridgement of his thesis, entitled "Carcinoma of the Epiglottis," appeared in the head and neck issue of American Journal of Surgery in December 1961.

Doctor Hitselberger received his medical training at Johns Hopkins University at Baltimore, Md., and his specialist training at Henry Ford Hospital in Detroit, Mich.

Dr. Pierpont Assumes New Duties

Dr. John Pierpont, formerly of Montreal, has moved with his family to White Pine where he will be medical director of the White Pine Copper Company's operations at White Pine.

Dr. Baumann Represents Alumni

Dr. Robert R. Baumann, Monroe, has been appointed a representative of the Johns Hopkins University National Alumni Schools Committee. He received degrees from Johns Hopkins University and the Johns Hopkins School of Medicine, and in his new capacity he is visiting local high schools.

Dr. Chelius Speaks at PTA Meeting

Dr. Carl Chelius, Cudahy health commissioner, spoke on children's health at a Washington school PTA meeting at Cudahy recently.

Dr. Levinson Receives Mount Sinai Post

Dr. Bernard Levinson, who formerly headed the medical educational program at St. Joseph's hospital in Syracuse, N. Y., has been appointed to the new position of Director of Medical Education at Mount Sinai Hospital in Milwaukee. Doctor Levinson will develop graduate and postgraduate education programs and also will do research in hematology at the hospital and at Marquette University School of Medicine.

Husband and Wife Open Medical Office

Dr. and Mrs. Charles H. Flint, formerly of Scobey, Mont., have opened an office for the practice of medicine, surgery and physical therapy at Minocqua.

Doctor Flint trained at Dartmouth and Columbia Medical Schools in Hanover, N. H., and New York City respectively and had surgical internship at Henry Ford Hospital, Detroit, and surgical residency in Grand Rapids, Mich. He then practiced in Hart, Mich., for 16 years except for 3 years in the army. From 1955 to 1958 he served a fellowship in physical medicine and rehabilitation at the Mayo Clinic. After being in charge of the Gottsche Rehabilitation Center in Thermopolis, Wyo., for two years, he returned to private practice in medicine and surgery in Montana.

Mrs. Flint, who is a registered physical therapist, was trained at the Mayo Clinic and had a three-year service in the Navy physical therapy department. Later she was in charge of a physical therapy department in Sheridan, Wyo., and after her marriage to Doctor Flint, she practiced physical therapy at Gottsche Rehabilitation Center.

Physicians Open New Family Clinic

Dr. A. C. Theiler and his associate, Dr. William Schultz, have opened a new Family Clinic in Kiel.

Dr. Puchner Addresses Women's Group

Dr. Thomas C. Puchner, Milwaukee, specialist in cardiology, spoke on "Cholesterol and Its Effect Upon the Heart" before the West Allis Vocational Day Homemakers' Club at the West Allis Vocational School recently.

Leaves Practice to Study Specialty

Dr. Kenneth Schroeder has left his private practice in Berlin, where he was associated with *Dr. L. J. Seward.* While working on the staff of a private sanitarium in Milwaukee, he plans to do postgraduate work in psychiatry for a period of several years.

Dr. Kundert Speaks on Mental Health

Dr. Elizabeth Kundert, Eau Claire, spoke to the Bloomer Woman's Club recently on "Mental Health, What Is It?"

WHA–TV "Quizzes" Dr. Miller

Dr. Milton H. Miller, chairman of the University of Wisconsin psychiatry department, participated in the "Quiz the Professor" program over the University of Wisconsin WHA–TV station in December. His subject was "Man's Attempts to be a Friend to Himself."

Dr. Peterman Gives Talk in Texas

Dr. M. G. Peterman, Milwaukee, addressed the Bexar Pediatric Society in San Antonio, Tex., on November 19, 1962.

Speaker at Medical Conference

Dr. G. B. Murphy, Jr., La Crosse, spoke on "Internship and Residency Programs" at the North Central Medical Conference held at Minneapolis, Minn., last November.

Moderates Mental Health Meeting Program

Dr. E. H. Jochimson, Sheboygan, moderated a program of the state meeting of Community Mental Health members and medical staffs from Wisconsin at the Manitowoc Health Center building in November.

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MEDICAL STAFF

William L. Herner, M. D., Medical Director
John F. Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Preston W. Thomas, M. D.
William H. McCreary, Jr., M. D.

RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, January 10, 1962.

Name	*School of Graduation*	*Year*	*City*
Apfelbach, George, Jr.	Northwestern University	1957	Racine
Busza, Alfons	University of Pozman	1933	Milwaukee
DeHaven, Howard T.	University of Louisville	1957	Milwaukee
Farbstein, Martin E.	University of Basel	1955	Hazel Green
Fodor, Richard L.	Ohio State University	1954	Milwaukee
Friedrichs, Edward S.	Northwestern University	1958	Madison
Goldschmit, Volker	University of Nuenchen	1946	Duluth, Minn.
Greuner, Carl E.	University of Frankfurt	1953	Winnebago
Grubs, Adrian W.	University of Rochester	1959	Milwaukee
Hawk, Edgar Allen	Indiana University	1942	Madison
Hesse, Siegfried F.	University of Iowa	1954	Rib Lake
Krueger, Thomas P.	Indiana University	1960	Madison
Lange, Ramon L.	Duke University	1949	Milwaukee
Langlois, Leslie, Jr.	University of Wisconsin	1957	Brookfield
Lazarovits, Peter	University of Budapest	1950	Lincoln, Ill.
Liss, George	George Washington University	1958	Milwaukee
Longstreth, Charles R.	University of Iowa	1958	St. Paul, Minn.
Nemeth, Charles	Peter Pazmany University	1934	Fond du Lac
Nesselbush, Orval P.	University of Nebraska	1958	Milwaukee
Ouellette, John J.	University of Vermont	1960	Madison
Page, Henry Felch	University of Pennsylvania	1934	Philadelphia, Pa.
Penhollow, Jack E.	University of New York	1960	Madison
Podobnikar, Ivan G.	University of Padua	1945	Columbus, Ohio
Pollard, William S.	University of Manitoba	1949	Duluth, Minn.
Ragheb, Moufid	Cairo University	1945	Montreal, Canada
Schwartz, Donald R.	University of S. California	1959	Madison
Shanahan, Mary P.	St. Louis University	1958	Milwaukee
Sinchugov, Igor	Rostov Medical School	1941	Passaic, N. J.
Thornton, Francis J.	University of Iowa	1957	Milwaukee
Wiita, Robert M.	Duke University	1955	Wood
Wyner, Stanley F.	University of Capetown	1948	Madison
Yu, Shao Chen	Rung-de Medical College	1940	Philadelphia, Pa.

The following physicians were granted licenses by written examination by the State Board of Medical Examiners at a meeting in Madison January 9, 10, 11, 1962.

Backus, Julia	University of Mainz	1953	Milwaukee
Birnbaum, Marvin	University of Wisconsin	1960	Madison
Castro, Robert Ramon	University of Paris	1958	Madison
Clemence, James Allen	Marquette University	1960	Milwaukee
Cunningham, Milfred A.	University of Wisconsin	1961	Madison
Diamond, Darryl Mark	University of Wisconsin	1961	Milwaukee
Eyvindsson, Elias	University of Iceland	1944	Winter
Feiges, Lewis Michael	University of Wisconsin	1961	Portland, Me.
Flannery, John V., III	Marquette University	1960	St. Paul, Minn.
Gasman, David H.	Marquette University	1959	Cass Lake, Minn.
Gee, J. Bernard L.	Oxford University	1953	Madison
Godin, Nicole,	University of Paris	1959	Madison
Haessly, Frederic G.	Marquette University	1957	Juneau
Hartman, Glen Walter	University of Wisconsin	1961	Browning, Mont.
Hauser, William E. D.	Marquette University	1960	Ft. Eustis, Va.
Herman, Mary Margaret	University of Wisconsin	1960	Madison
Ibler, Irene Mary	University of Witwatersrand	1952	Madison
Jameson, Harry D.	University of Wisconsin	1958	Madison
Jones, Richard James	University of Wisconsin	1961	Marshfield
Koeller, Arlyn Arnold	University of Wisconsin	1961	Ashland
Kopf, George Michael	University of Wisconsin	1961	Milwaukee
Loken, Kenneth Odell	University of Wisconsin	1961	Middleton
Manis, Robert	University of Wisconsin	1961	Fond du Lac
Mathison, Johan Alfred	University of Wisconsin	1961	Viroqua
Neuhauser, Charles A.	University of Wisconsin	1961	Madison
Nowinski, Donald M.	University of Wisconsin	1961	Wausau
Ottensmeyer, David J.	University of Wisconsin	1959	Madison
Paluska, Donald John	Marquette University	1961	Milwaukee
Pawsat, Richard A.	University of Wisconsin	1961	Los Angeles, Cal.
Plater, Richard W.	University of Wisconsin	1961	Madison
Ryan, Richard H.	Marquette University	1957	Milwaukee
Schoene, Fred C.	George Washington University	1945	Phoenix, Ariz.

Name	*School of Graduation*	*Year*	*City*
Schwab, Donald Francis	University of Wisconsin	1961	Madison
Sehler, Burton	University of Wisconsin	1961	Chicago, Ill.
Spieker, Diane Mary	Marquette University	1961	Racine
Precher, James J. J.	University of Wisconsin	1961	Ft. Atkinson
Stafford, Richard D.	University of Wisconsin	1961	Madison
Staves, Nicholas P.	University of Athens	1949	Flint, Mich.
Stein, Leonard Irving	University of Wisconsin	1961	Madison
Strauch, Axel E.	University of Wisconsin	1961	Riverside, Cal.
Underberg, John Thomas	University of Wisconsin	1961	St. Clair, Mich.
Utrie, John Wendel	Marquette University	1959	Redlake, Minn.
Vechinski, Thomas O.	University of Wisconsin	1961	Madison
Vognar, Stanley	Medical Faculty—Zagreb	1948	Mt. Horeb
Wagener, Nicholas R.	University of Wisconsin	1957	Sturgeon Bay
Wicker, Donald Douglas	University of Wisconsin	1961	East Ely, Nev.
Zarem, Norton	University of Wisconsin	1961	Milwaukee

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Madison, April 13, 1962.

Arida, Gamil T.	Alexandria University	1948	Joliet, Ill.
Barber, Jergen L.	University of Nebraska	1959	Madison
Boardman, Charles R.	University of Chicago	1955	Beloit
Burnell, Ernest L.	University of Arkansas	1957	Milwaukee
Cameron, Alan Bruce	Harvard Medical School	1956	Marshfield
Dam, Michael Edward	Marquette University	1958	Beaver Dam
Darby, Roderick E.	Northwestern University	1961	Milwaukee
Effenhauser, Manfred	Albert Ludwigs University	1958	Winneconne
Evans, William E.	Ohio State University	1961	Milwaukee
Ferrari, Joseph J.	New York Medical College	1948	Green Bay
Fueredi, Adam	Marquette University	1961	Milwaukee
Gaute, Svend T.	University of Copenhagen	1948	Minneapolis, Minn.
Goepfert, Mary	University of Minnesota	1952	Minneapolis, Minn.
Goldberg, Elliott, M.	Tufts University	1956	Madison
Gonlag, Harry	Indiana University	1961	Eau Claire
Gungor, Bahri O.	Istanbul University	1954	Loyal
Gursoy, Erdal Y.	Ankara University	1956	Winnebago
John, Robert H.	University of Minnesota	1956	New Berlin
Just, John F.	University of Illinois	1961	Milwaukee
Kirch, Everett P.	Northwestern University	1939	Kenosha
La Flare, Joseph P.	Long Island Col. of Medicine	1945	Green Bay
Laukenmann, Bernhard	University of Munich	1955	Hyde, Md.
Love, Robert G.	University of Maryland	1952	Cuba City
Mangru, Bala	University of Nuevo Leon	1957	Cleveland, Ohio
Moffat, Nelson, A.	University of Chicago	1955	Marshfield
Murphy, Thomas R.	Dalhousie University	1956	Stillwater, Minn.
Owen, George E.	Cornell University	1956	Syracuse, N. Y.
Radich, Branko	Bologna University	1938	Winnebago
Reed, Ray D.	University of Texas	1949	Eau Claire
Richards, William R.	Washington University	1957	
Rohr, Mary-Elaine H.	Temple University	1940	Pawtucket, R. I.
Schnicke, Elmer H.	Chicago Medical School	1937	Wyanet, Illinois
Schroeder, Kenneth P.	Marquette University	1961	Berlin
Slette, Darrell R.	George Washington University	1958	Appleton
Sneed, Robert J.	University of Wisconsin	1957	Ashland
Welch, William M.	University of Pittsburgh	1959	Marshfield
Windeck, James L.	University of Illinois	1959	Chippewa Falls

The following physicians were granted licenses by written examination by the State Board of Medical Examiners at a meeting in Milwaukee July 10, 11, 12, 1962.

Altman, S. David Paul	University of Wisconsin	1961	Milwaukee
Beck, John Robert	Marquette University	1960	Otis AFB, Mass.
Block, Robert Theodore	University of Wisconsin	1961	Madison
Boake, William Charles	University of Melbourne	1948	Madison
Casao, Roberto Lopez	University of Mexico	1954	Milwaukee
Casey, Peter Nicholas	Marquette University	1961	Milwaukee
de Oliveira, Mario M.	University of Brazil	1956	Milwaukee
Donarski, David P.	Marquette University	1960	Ft. Bragg, N. C.
Falk, Manuel James	University of Wisconsin	1961	Green Bay
Frable, Mary Ann	Northwestern University	1959	Chicago, Ill.
Gerhard, Clyde	University of Wisconsin	1961	San Antonio, Tex.
Gustafson, Glenn E. Jr.	University of Illinois	1961	Menasha
Halloran, William R.	Marquette University	1961	Glendale
Held, William John	Marquette University	1961	Milwaukee
Holmen, Gerald James	University of Wisconsin	1961	San Antonio, Tex.

Name	*School of Graduation*	*Year*	*City*
Hotchkiss, Frederick L.	University of Wisconsin	1961	Toledo, Ohio
Kampine, John Paul	Marquette University	1961	Marathon
Kimmey, James R. Jr.	University of Wisconsin	1961	Madison
Krohn, Eugene	University of Wisconsin	1959	Black River Falls
Lee, Connie Corlett	University of Wisconsin	1961	La Farge
Leering, Hendrik	University of Utrecht	1956	Reedsville
Lefsrud, John B.	University of Alberta	1956	La Crosse
Leissring, John C.	University of Wisconsin	1961	San Francisco, Cal.
Malueg, Thomas John	University of Wisconsin	1961	Madison
Maranan, Isidro Lastima	University of Santo Tomas	1956	Milwaukee
McBeath, Andrew Alan	University of Wisconsin	1961	Hartford, Conn.
Minhoseini, Mahmood	University of Teheran	1955	Athens
Mohanty, Raja Kishore	Sriram Chandra Bhanj Med. Col.	1949	Milwaukee
Olsen, Dennis Richard	University of Wisconsin	1961	New Hampton, Ia.
Plos, James Robert	University of Wisconsin	1961	San Antonio, Tex.
Eoob, Doris Mae	University of Wisconsin	1961	Cudahy
Rozansky, Norman	University of Chicago	1960	Iowa City, Ia.
Russo, Vincent Otto	University of Wisconsin	1961	Wauwatosa
Scholwater, John Erwin	University of Wisconsin	1960	Cincinnati, Ohio
Shelp, Weldon Donald	University of Wisconsin	1961	Madison
Simeon, Rodolfo G.	University of Santo Tomas	1952	Madison
Speckhard, Mark Evan	University of Wisconsin	1961	Clintonville
Spiegel, Carol Lois	University of Wisconsin	1961	Manitowoc
Stein, Bernhardt E.	University of Wisconsin	1961	South Bend, Ind.
Stula, Gojko D.	University of Belgrade	1958	Milwaukee
Vinluan, Alejandro M.	University of Santo Tomas	1955	Milwaukee
Welch, Martin Henry	University of Wisconsin	1961	Toledo, Ohio
Yard, Albert Charles	Marquette University	1961	Milwaukee
Yutuc, Wildrido R.	University of Philippines	1957	La Crosse

Special written examination given September 10, 11, 12, 1962 in Madison.

Farias, Oscar Alberto	Cordoba National University	1949	Hawthorne

The following physicians were granted licenses by oral examination by the State Board of Medical Examiners at a meeting in Milwaukee July 11, 1962.

Alt, Thomas H.	Indiana University	1961	Menasha
Banach, Alexius	Jagiellonski University	1931	Newberry, Mich.
Bauman, Billy J.	Indiana University	1953	South Bend, Ind.
Beckfield, William J.	University of Pennsylvania	1944	Eau Claire
Bellini, Albert Carl	Loyola University	1931	Milwaukee
Benner, Marshall H.	Marquette University	1961	Milwaukee
Blatnik, Donald S., Sr.	Marquette University	1961	West Allis
Brailey, Allen G., Jr.	Boston University	1956	La Crosse
Christensen, Robert Q.	University of Iowa	1958	Menomonie
Corcoran, William, Jr.	University of Michigan	1961	Port Washington
Curet, Luis B.	University of Puerto Rico	1958	Madison
Dahl, Diane Anita	University of Wisconsin	1956	Mahtomedi, Minn.
Damon, Richard A.	University of Iowa	1957	Waupun
Deshazo, Billy W.	University of Texas	1956	Madison
Dowling, Jerome J., Jr.	Marquette University	1961	Wauwatosa
Duxbury, William J.	George Washington University	1960	Fox Lake
Everett, Henry C.	Johns Hopkins University	1955	Madison
Farkas,, Mary E.	Marquette University	1961	Milwaukee
Feller, H. Allan	University of Cincinnati	1960	Milwaukee
Frey, Thomas	Northwestern University	1958	Madison
Geocaris, Konstantin	Northwestern University	1949	Madison
Geppert, Charles H.	Washington University	1957	Madison
Giaquinto, Eugene L.	University of Lausanne	1959	Madison
Grace, Eugene V.	University of Michigan	1956	Monroe
Grossman, Ronald E.	Marquette University	1961	Milwaukee
Handte, Robert E.	New York Medical College	1953	Menasha
Heidenrhich, William	Yale University	1955	Dubuque, Iowa
Hodges, Paul C., Jr.	Johns Hopkins University	1955	Appleton
Hoerr, Gene Otto	University of Illinois	1960	Milwaukee
Holder, Donald H.	University of Iowa	1961	Milwaukee
Holten, David R.	Temple University	1960	Osceola
Jennison, Marshall R.	Ohio State University	1961	Milwaukee
Kaplan, Marvin S.	University of Illinois	1961	Madison
Kastelic, Robert	Marquette University	1961	Milwaukee
Kauth, James P.	Marquette University	1961	Port Washington
Kempthorne, Gerald	University of Maryland	1961	Spring Green
Kopp, William L.	University of Michigan	1954	Madison

Name	*School of Graduation*	*Year*	*City*
Kyllonen, Ronald R.	University of Minnesota	1957	Madison
Lindgren, Richard D.	University of Iowa	1956	Madison
Lucas, George L.	George Washington University	1961	Madison
Ludwig, Arthur S., Jr.	St. Louis University	1961	Osceola
Massart, John J.	Marquette University	1961	Milwaukee
McBride, Frank F.	Marquette University	1961	Milwaukee
McCreary, William H.	Vanderbilt University	1957	Milwaukee
Montgomery, Edwin G.	Marquette University	1961	Milwaukee
Myers, Robert Earl	Marquette University	1961	Milwaukee
Peters, Kenneth R.	Marquette University	1961	Milwaukee
Peterson, Arthur K.	University of Illinois	1937	Delavan
Pohlmann, Guenther P.	Marquette University	1961	Milwaukee
Ramsey, Warne F.	University of Iowa	1961	Menomonie
Rashid, Ameel G.	Loyola University	1959	Milwaukee
Richany, Shafik F.	University of Wisconsin	1957	Wood
Richards, Robert N.	University of Pennsylvania	1958	Marshfield
Rosenbloom, Arlan L.	University of Wisconsin	1958	Madison
Ryan, Thomas A.	University of Iowa	1961	Milwaukee
Schoenbeck, Phillip	University of Wisconsin	1957	Stoughton
Snook, William H.	George Washington University	1960	Fox Lake
Snyder, Leonard E.	Northwestern University	1961	Wauwatosa
Sproul, John M.	Northwestern University	1958	Milwaukee
Thompson, Walter C.	Loma Linda University	1961	Guam, M. I.
Thornton, Richard R.	Harvard Medical School	1960	Milwaukee
Torkelson, Leif O.	University of Virginia	1957	Madison
Trygstad, Carl W.	University of Florida	1961	Madison
Unger, George F., Jr.	Jefferson Medical College	1957	Elm Grove
Unger, June DeBoer	Woman's Medical College	1958	Elm Grove
Veranth, Jerome J.	Marquette University	1961	Milwaukee
Vondrak, Ben Frank	University of Illinois	1961	Milwaukee
Wagner, Harold B.	University of Chicago	1950	Chicago, Ill.
Williams, Joseph P., Jr.	University of California	1961	Milwaukee
Winter, Robert S.	Washington University	1958	St. Paul, Minn.
Yeazel, Roy V.	Marquette University	1961	Madison

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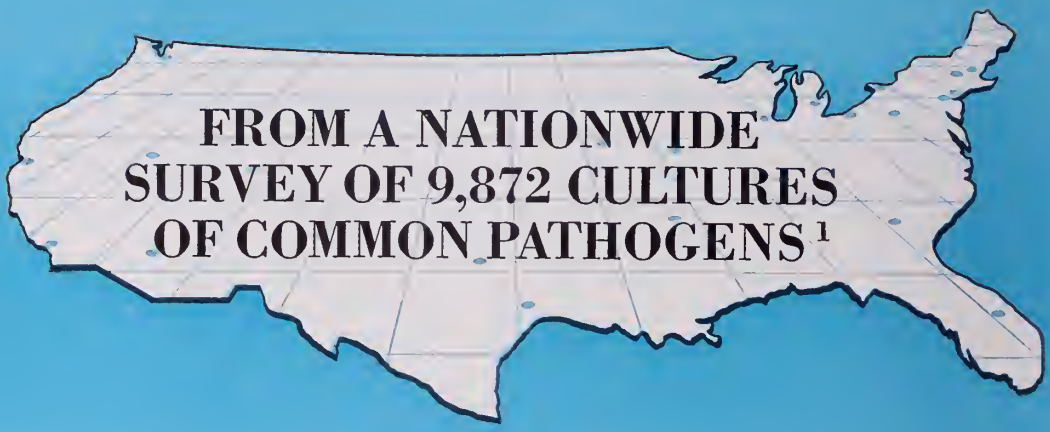

Conclusions of Nationwide Survey: *Report I*

1. **Even after five years of general use,** Tao, of the antibiotics tested, demonstrated greatest activity against respiratory streptococci and staphylococci (3,332 cultures).

2. **Overall results showed a higher percentage of susceptibility** among these common pathogens to Tao than to the other antibiotics. Susceptibility to Tao was greatest, not only in respiratory streptococci and staphylococci, but also in these organisms isolated from skin and soft tissue (3,423 cultures), genitourinary and gastrointestinal tracts and other sources (2,458 cultures). Susceptibility was equal to all antibiotics tested in pneumococci from unspecified sources (463 cultures), and less to Tao in H. influenzae from unspecified sources (196 cultures).

3. **Tao has been used for five years without development of predictable cross resistance.** In 1958 and 1961, approximately 73% and 70%, respectively, of erythromycin-resistant problem staphylococci showed susceptibility to Tao.[3,4] The present study confirms the continuing high degree of Tao activity even against these pathogens. Of 1,592 cultures of erythromycin-resistant staphylococci, 68% were susceptible to Tao, while in the reverse situation, only 33% of 768 Tao-resistant staphylococci were susceptible to erythromycin.

CALENDAR OF MEETINGS

1963 **Wisconsin**

Mar. 7: Postgraduate course on Some Orthopedic Problems Occurring in General Practice, University of Wisconsin Medical Center, Madison.

Mar. 7–9: Postgraduate course on The Hemiplegic Patient, University of Wisconsin Medical Center, Madison.

Mar. 8: Public lecture on The Brain, Too, Has Arteries, Dr. Paul Dudley White, Boston at 4 p.m., University of Wisconsin Medical School, Madison.

Mar. 20: Poison control seminar, sponsored by State Board of Health and others, at State Medical Society headquarters, Madison.

Mar. 21–23: Postgraduate course on Advances in Immunology and Hypersensitivity, University of Wisconsin Medical Center, Madison.

Mar. 27: SMS teaching program on Strokes, Janesville.

April 3–5: Seminar on Bobath Approach to the Treatment of Cerebral Palsy, Central Wisconsin Colony and Training School, Madison.

Apr. 4: SMS teaching program on Clinical Electrocardiography, Oshkosh.

April 18–19: Annual meeting, Wisconsin Anti-Tuberculosis Association, Pfister Hotel, Milwaukee.

Apr. 18–20: Health Fads and Fallacies symposium, State Medical Society headquarters, Madison.

April 25–27: Postgraduate course on Renal Diseases in Childhood, University of Wisconsin Medical Center, Madison.

May 6–9: State Medical Society of Wisconsin annual meeting, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

1963 **Out-of-State**

Mar. 4–6: Meeting of Canadian-American Medical and Dental Ski Association, Iroquois Mountain, Brimley, Mich.

Mar. 4–7: Annual meeting of the New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La.

Mar. 4–8: Postgraduate course on Physical Methodology in Medical Research, Massachusetts Institute of Technology, American College of Physicians, Massachusetts Institute of Technology, Cambridge, Mass.

Mar. 8–9: AMA Medicolegal Symposium, Americana Hotel, Miami Beach, Florida.

Mar. 11–13; 18–20: Clinical Reviews, Mayo Clinic and Mayo Foundation for Medical Education and Research, Mayo Civic Auditorium, Rochester, Minn.

Mar. 11–14: Annual sectional meeting, American College of Surgeons, Penn–Sheraton Hotel, Pittsburgh, Pa.

Mar. 16–21: Fifteenth Annual Teaching Seminar of the International Academy of Proctology, Las Vegas, Nev.

Mar. 18–21: American Industrial Health Conference, Sheraton–Park Hotel, Washington, D.C.

Mar. 18–23: Postgraduate course on Recent Advances in Cardiovascular Disease, American College of Physicians, The Mount Sinai Hospital, New York.

Mar. 24–29: American College of Allergists Graduate Instructional Course and Nineteenth Annual Congress, Americana of New York, New York City.

Mar. 25–29: American Society of Anesthesiologists Biennial Western Conference on Anesthesiology, Hawaiian Village, Honolulu.

Mar. 28–30: Fourth Oklahoma Colloquy on Advances in Medicine: Pulmonary Insufficiency, Oklahoma City, Okla.

June 10–13: Convention of the Catholic Hospital Association of the United States and Canada, Conrad Hilton Hotel, Chicago.

Nov. 5–13: Ninth Congress of the Pan–Pacific Surgical Association, Honolulu, Hawaii.

Nov. 13–Dec. 10: First Pan–Pacific Mobile Educational Lecture Seminar, New Zealand, Australia, Thailand, the Philippines, Hong Kong and Japan.

Medical Meetings
Postgraduate Courses

American Board of Obstetrics and Gynecology

The next scheduled examination (Part II), oral and clinical, will be conducted by the entire American Board of Obstetrics and Gynecology for all candidates at the Edgewater Beach Hotel, Chicago, Ill., April 29 to May 4, 1963. Formal notice of the exact time of each candidate's examination will be sent him or her in advance of the examination dates.

Current bulletins of the American Board of Obstetrics and Gynecology outlining the requirements for application may be obtained by writing to the Secretary, Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio. All prospective candidates are urged to review the current requirements before applying for Board examination.

Diplomates are requested to keep the Board office informed of a change in address.

American College of Physicians

The American College of Physicians will present a postgraduate course on "Recent Advances in Cardiovascular Disease" March 18 to 22 at the Mount Sinai Hospital, New York, N. Y.

Minimal registration for the course will be 50; maximal registration, 200. Fee for A.C.P. members, $60; nonmembers, $80.

Send all registrations, requests for information and application blanks to: Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia 4, Pa.

Medical College of Georgia

Office care and certain minor surgical procedures will be emphasized in the postgraduate course, "Gynecologic Problems in Private Practice," to be held at the Medical College of Georgia March 12, 13 and 14.

The course, covering subjects of interest in the management of the private gynecologic patient, will also include functional and endocrine disturbances and certain aspects of infertility.

Each course is acceptable for 18 hours credit by the American Academy of General Practice. Registration is limited to a small group for close faculty-participant communication. Registration fee: $50. Application can be made by contacting Dr. Claude–Starr Wright, Director, Department of Continuing Education, Medical College of Georgia, Augusta, Ga.

Wisconsin Urological Society

The Wisconsin Urological Society will hold its thirty-sixth annual meeting on April 19 and 20 in

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Milwaukee. Guest speaker at the meeting will be Donald F. McDonald, M.D., professor of urology, Strong Memorial Hospital, University of Rochester, Rochester, N. Y.

American College of Surgeons

The Chicago Committee on Trauma of the American College of Surgeons announces the Seventh Postgraduate Course in Trauma to be held April 24 to 27 at the John B. Murphy Memorial Auditorium, Chicago, Ill.

Walter P. Blount, M.D., clinical professor and head of the department of orthopedic surgery, Marquette University School of Medicine, Milwaukee, will be one of the lecturers.

Registration fee for the course, which is acceptable for 31½ hours of Category II credit by the American Academy of General Practice, is $75. Residents and interns will be admitted by letter from chief of service. Advance registration may be made with Dr. John J. Fahey, 1791 Howard St., Chicago 26, Ill.

Institute on Preventive Psychiatry

"Creative Approaches to Environmental Stresses" will be the general theme of the fourth Institute on Preventive Psychiatry to be held April 26 and 27 at The State University of Iowa, Iowa City.

Main speakers at the Institute will be: Richard Alpert, Harvard University; Ronald Lipitt, University of Michigan; John McCollum, U. S. Department of Health, Education and Welfare; Albert I. Norris, State University of Iowa; Julius Richmond, M.D., Syracuse University Medical School, and Robert Tannenbaum, University of California, Los Angeles.

Requests for programs and other inquiries may be directed to William D. Coder, director of conferences and institutes, State University of Iowa, Iowa City.

North Central Allergy Society

The North Central Allergy Society will hold its fourth annual meeting May 4 and 5 at the Pfister Hotel, Milwaukee. Interested physicians are invited to attend the program which is scheduled from 2 to 5 p.m. on May 4 and 9:30 to 11:30 a.m. on May 5.

Inquiries on program and reservations may be directed to Harry R. Weil, M.D., Program Chairman, 1212 W. Wisconsin Ave., Milwaukee 3, Wis.

American Thoracic Society

Scientific papers, round table discussions, and luncheon seminars on clinical and laboratory work in tuberculosis and other respiratory diseases are being planned for the annual meeting of the American Thoracic Society to be held May 13, 14 and 15 at Denver, Colo. The ATS, which is the medical arm of the National Tuberculosis Association, will meet in conjunction with the fifty-ninth annual meeting of the Association.

Subjects to be discussed at "sandwich seminars" scheduled during lunchtime May 13 and May 15 include: respiratory emergencies in the perinatal period, the meaning of pulmonary diffusing capacity, unclassified mycobacteria, primary drug resistance for tuberculosis, tuberculin testing, the management of the flail chest, and medical education.

Round table discussions, to be conducted during the final period each afternoon, will include: airborne transmission of infections, retreatment of drug-resistant tuberculosis, etiological aspects of newer environmental lung disease, histoplasmosis, ventilatory assistance, and viral respiratory disease in man.

The Amberson Lecture, a special event of each ATS annual meeting, will be held at 11 a.m. Tuesday, May 14, and will be followed by the annual business luncheon of the society.

American College of Chest Physicians

The American College of Chest Physicians has announced the following schedule of forthcoming national and international meetings and postgraduate courses:

National and International Meetings

Twenty-ninth annual meeting, Ambassador Hotel, Atlantic City, June 13 to 17.

Interim clinical meeting, Portland, Ore., November 30, December 1.

Eighth International Congress on Diseases of the Chest, Mexico City, Oct. 11–15, 1964.

Postgraduate Courses

Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs:

October 14 to 18, Washington, D. C.
November 11 to 15, New York City
December 2 to 6, Los Angeles, Calif.
January 13 to 17, 1964, Miami Beach, Fla.

Clinical Cardiopulmonary Physiology, Chicago, Ill., October 21 to 25.

Complete details of all meetings and postgraduate courses may be obtained by writing Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 East Chestnut St., Chicago 11, Ill.

American Rhinologic Society

Forty-five specialists in rhinology from the United States, Mexico, Scotland, Australia, Israel, France and The Netherlands will constitute the invited faculty for the fifth International Postgraduate Course in Reconstructive Surgery of the Nasal Septum and External Pyramid, to be presented at the University of Leiden, The Netherlands, July 14 to 27.

The course, directed by Prof. H. A. E. van Dishoeck of the University of Leiden, will be presented with the cooperation of the American

Rhinologic Society. Maurice H. Cottle, M.D., professor of otorhinolaryngology at the Chicago Medical School, will be the guest professor.

Among the distinguished guests will be Sir Victor Negus of London, consulting surgeon to the ear, nose and throat department of King's College Hospital, and Prof. Dr. C. A. Hamburger of the Karolinska Institute, Stockholm, Sweden.

English will be the official language. Class membership is limited.

For further information write to: (1) Prof. Dr. H. A. E. van Dishoeck, University of Leiden, Academisch Ziekenhuis, Leiden, The Netherlands, or (2) American Rhinologic Society, 530 Hawthorne Place, Chicago 13, Ill.

Scripps Clinic and Research Foundation

A nine-month tutorial program in cardiology will be offered by the Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif., Sept. 15, 1963 to June 15, 1964.

This will be an intensive academic effort covering the field of cardiovascular diseases and is especially designed for the practitioning physician who desires thorough instruction in this field and for the physician who is finishing his period of formal training and wants a final intensive orientation in cardiology.

For details, write: Executive Secretary, Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

American College of Obstetricians and Gynecologists

The 11th Annual Clinical Meeting of the American College of Obstetricians and Gynecologists will be held at the Statler Hilton Hotel in New York City April 21–24, 1963.

American Pharmaceutical Association

The 1963 annual meeting of the American Pharmaceutical Association will be held at the Americana Hotel, Bal Harbour, Miami Beach, Fla., May 12–17.

Industrial Medical Association

More than 50 scientific papers will be presented at the 1963 American Industrial Health Conference which will be held at the Sheraton–Park Hotel in Washington, D.C., March 18 to 21. This medical-nursing conference is staged annually by the Industrial Medical Association and the American Association of Industrial Nurses.

The program will include reports from well known authorities on such subjects as criteria for disability evaluation, silicosis in the metal mining industry, new therapeutic approaches to primary myocardial disease, newer concepts of shock, the role of the physician in space medicine, the common cold syndrome, the woman worker from the gynecological viewpoint, and occupational mono-neuropathies.

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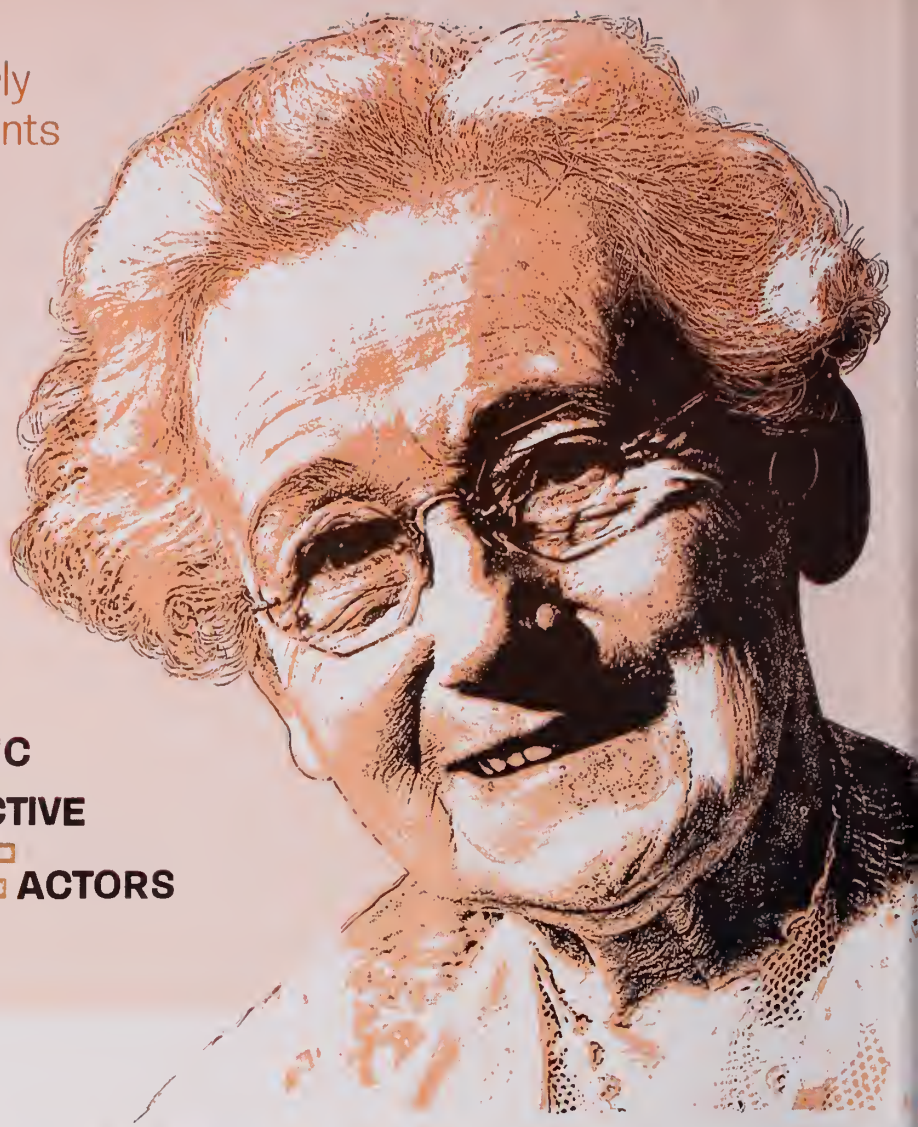

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1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

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In addition to the scientific program, the Occupational Health Institute, educationl affiliate of the Industrial Medical Association, is offering intensive refresher courses on cardiology in industry, dermatology in industry, ophthalmology in industry, disability evaluation, and office and clinic proctoscopy.

Participation in the conference is open to anyone who desires to attend.

Catholic Hospital Association

"Quality: Planned and Evaluated" will be the theme of the 1963 convention of the Catholic Hospital Association of the United States and Canada to be held at the Conrad Hilton Hotel, Chicago, June 10 through 13.

Wisconsin Anti-Tuberculosis Association

The 1963 annual meeting of the Wisconsin Anti-Tuberculosis Association will be held at the Pfister Hotel, Milwaukee, on April 18 and 19, 1963.

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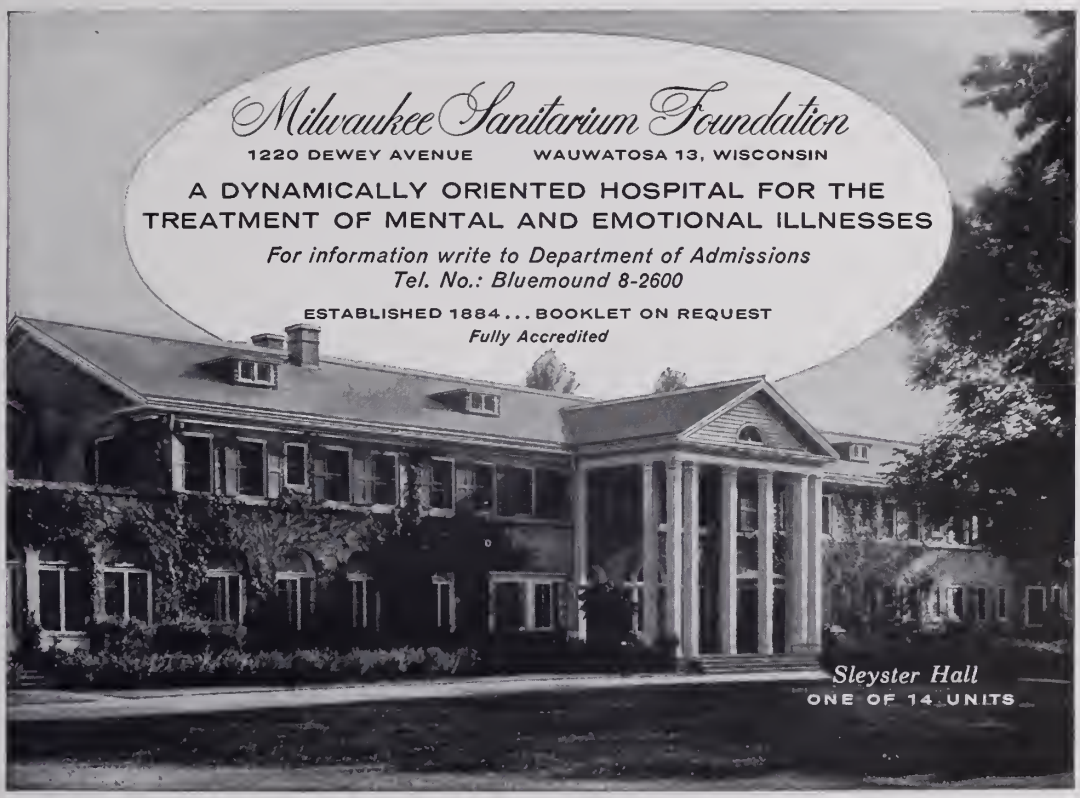

A PROJECT OF THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN, BOX 1109, MADISON 1, WIS.

THREE TEACHING PROGRAMS

GREEN BAY: Thursday, March 21, St. Vincent's Hospital

JANESVILLE: Wednesday, March 27, Mercy Hospital

OSHKOSH: Thursday, April 4, Mercy Hospital

1

MATERNAL MORTALITY INSTITUTE—March 21, St. Vincent's Hospital, Green Bay, 2 to 5 p.m.

UNEXPECTED MASSIVE HEMORRHAGE: *Ben M. Peckham*, M.D., professor and chairman, department of obstetrics and gynecology, University of Wisconsin Medical School

MANAGEMENT OF THE OBESE PREGNANT FEMALE: *George S. Kilkenny*, M.D., associate clinical professor of obstetrics and gynecology, Marquette University School of Medicine

OXYTOCICS—EMPLOYMENT AND SAFEGUARDS: *John R. Evrard*, M.D. assistant clinical professor of obstetrics and gynecology, Marquette University School of Medicine

CATASTROPHY OF THE ABRUPTIO PLACENTA: *Frederick J. Hofmeister*, M.D., associate clinical professor of obstetrics and gynecology, Marquette University School of Medicine

Moderator: T. A. Leonard, M.D.
Chairman, Wisconsin Maternal Mortality Study Committee

A.A.G.P. CREDITS: 3 Hours of Category I

ATTENDANCE: Open to all MDs, hospital administrators, OB nurses and other certified hospital personnel. No registration fee, but it will be appreciated if you will indicate your intention to attend.

COOPERATING SPONSORS: Wisconsin State Board of Health and the Charitable, Educational and Scientific Foundation of the State Medical Society.

2

STROKES—WHAT CAN WE DO ABOUT THEM?—March 27, Mercy Hospital, Janesville, 2 to 5 p.m.

DIAGNOSIS AND DIFFERENTIAL DIAGNOSIS OF STROKES: *Richard H. Strassburger*, M.D., clinical instructor in neurosurgery, Marquette University School of Medicine

MEDICAL MANAGEMENT OF STROKES: *Mark J. Ciccantelli*, M.D., assistant clinical professor of medicine, Marquette University School of Medicine

SURGERY IN RELATION TO STROKES: Indications and Techniques, *Walter J. Woloschek*, M.D., clinical instructor in surgery, Marquette University School of Medicine

PHYSICAL THERAPY AND REHABILITATION OF THE STROKE PATIENT (with particular reference to what can be done locally, where specialized rehabilitation facilities are not available): *Edwin C. Welsh*, M.D., clinical professor of physical medicine and rehabilitation, Marquette University School of Medicine

A.A.G.P. CREDITS: 3 Hours of Category I

COOPERATING SPONSORS: Wisconsin State Board of Health and the Merck Sharp & Dohme Postgraduate Program.

3

CLINICAL ELECTROCARDIOGRAPHY (An Intensive 5-hour Review)—March 27, Mercy Hospital, Janesville, 9:30 a.m. to 4 p.m.

INSTRUCTION BY: *Richard H. Wasserburger*, M.D., chief of cardiology, V.A. Hospital, Madison, and associate clinical professor of medicine, University of Wisconsin Medical School.

Instruction will begin promptly at 9:30 a.m. Areas to be covered are: Genesis of the Normal Electrocardiograms; Cardiac Arrhythmias; Common Electrocardiographic Abnormalities; Changes with Pulmonary Emphysema, Anxiety, Mitral Stenosis, etc.; Coronary Heart Disease, and Myocardial Infarction.

A.A.G.P. CREDITS: 5 Hours of Category I

LIMITED ATTENDANCE: Only 40 MDs. Advance registration is necessary, so if you wish to enroll, please notify SMS.

DO NOT MAIL YOUR LUNCHEON FEE. THIS WILL BE COLLECTED WHEN YOU COME TO THE MEETING.

COOPERATING SPONSORS: Wisconsin Heart Association, Wisconsin State Board of Health and the Charitable, Educational and Scientific Foundation of the State Medical Society.

Classified Advertisements

Advertisements in this section are accepted in two categories: PHYSICIANS' EXCHANGE and COMMERCIAL.

RATES: 10¢ per word, with o minimum charge of $4.00 per od. Additionol insertions of some ad at one-half price eoch, maximum time one year. Display: $10.00 per column inch.

DEADLINE: Copy must be received by the 15th af the month preceding month of issue. Send copy to: Wisconsin Medical Journal, Box 1109, Madison 1, Wis.; or phone Alpine 6–3101.

PHYSICIANS' EXCHANGE: This section is limited to physicians and others desiring physicion placement, sole of medical practice or equipment of o physicion, sale or lease af medical buildings, etc. Advertisements fram individuol members af the State Medicol Society of Wisconsin are accepted without charge. Widows of deceased member physicions are allawed to odvertise without charge. The rates quoted abave apply ta ads ploced by clinics and others. There is no additional charge for ads with Dept. numbers. For these ads, address replies to: Dept. ___, % Wiscansin Medical Journol, Box 1109, Modison 1, Wis. Advertisers using Dept. numbers farbid the disclasure of their identity. All inquiries are farworded to them immediately.

COMMERCIAL: Advertisements are accepted at the obove rates from individuals, firms, organizations, etc., who ore reputable, have o good credit rating and advertise products or services af ethical standards. The Journal reserves the right to reject any odvertising. Advertisements from member physicians are also accepted ot the obove rates.

PHYSICIANS' EXCHANGE

WANTED: PHYSICIAN AND SURGEON in Bottineau, North Dakota. Very good town, and larger practicing territory to draw from. Sigurd Sigurdson, Bottineau, N. D. p1–3

WANTED: PSYCHIATRISTS or young doctors, interested in psychiatry to work at Mendota State Hospital. These positions are permanent and under Civil Service; salary depends upon previous experience and training. Housing available on grounds. Contact W. J. Urben, M.D., Superintendent, Madison 4, Wis. g10tfn

FOR SALE: UNOPPOSED small town general practice, southwestern Wisconsin. Modern, well equipped, air conditioned building, excellent open staff hospital nearby. Annual gross over $50,000. Contact Dept. 999 in care of the Journal. m8tfn

WANTED: ASSOCIATE IN GENERAL PRACTICE. Established practice in Minocqua resort area which is showing rapid growth, boasts good grammar schools and three-year-old million dollar high school, 20-bed hospital with open staff and nearly completed new addition which will double bed capacity. Own clinic building which consists of waiting room, business office, five examining rooms, laboratory. Salary for first year $1,000 per month. Second year salary plus percentage of gross. Partnership at five years. Start now. Contact Dept. 997 in care of the Journal. m7tfn

FOR SALE: Two level home and office on bank of river; 45-acre estate near town of 6,000, 70 miles north of Madison. Hospital, good schools, several churches. Man with surgical training desirable. Purchase may be made by land contract. Might consider a locum tenens with potential permanent arrangement. A highly flexible opportunity for the right person. Contact Dept. 23 in care of the Journal. m12tfn

WANTED: GENERAL PRACTITIONER as associate. Immediately available opportunity to practice in well established group of two. Replacement for sudden loss of partner. Eventual partnership. 126 E. Main Street, Madison. AL 6–3171. m9tfn

FOR SALE: GENERAL PRACTICE in small town in Wisconsin. Will introduce and accept reasonable offer. Contact Dept. 14 in care of the Journal. m10tfn

URGENTLY NEEDED: General practitioner for association with three physicians, to start as soon as possible. Central Wisconsin city. Salary—the going rate—with $1,000 per month minimum, and partnership as soon as mutually desired. Contact Dept. 984 in care of the Journal. m5tfn

POSITION WANTED: RADIOLOGIST, Board eligible, University training in diagnosis and therapy, hospital and private practice experience, desires position with hospital or association. Contact Dept. 995 in care of the Journal. m7tfn

POSITION WANTED: RADIOLOGIST, certified, seeks position preferably in solo practice. Experienced, University-trained. Contact Dept. 979 in care of the Journal. 4tfn

FOR SALE: Established EENT practice, over 40 years in the heart of Milwaukee. Excellent referrals; will introduce; retiring. Contact Dept. 24 care of the Journal. m12tfn

FOR SALE: Cystoscopic table in very good condition. Name your price. Call or write Badger Medical Supply Co., 702 S. Park St., Madison, Wis., ALpine 6–1801. 12–2

WANTED: INTERNIST, Board certified, to join two established surgeons. Excellent office facilities. Opposite 300-bed hospital—200-bed added expansion in progress. Town of 15,000. Central Wisconsin. Guaranteed salary. Percentage and partnership early prospects. Contact Dept. 981 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER to associate with two young general practitioners in established three-man clinic, located in west central Wisconsin. Excellent new facilities built to handle growing practice. Hospital and recreational facilities excellent. Early partnership for right man. Contact Dept. 996 in care of the Journal. m7tfn

WANTED: PEDIATRICIAN for newly organized group in Fox River Valley of Wisconsin. One other pediatrician in community of 45,000. Excellent living conditions, noted recreational area and above average opportunity. Salary two years, then partnership. Contact Dept. 6 in care of the Journal. m9tfn

GENERAL PRACTICE FOR SALE. Physician desiring own x-ray equipment may purchase radiographic, fluoroscopic and therapy equipment. Seven-room office on main corner in southern Wisconsin city of 35,000 occupied for over 40 years. Wish to retire. Reasonable price. Contact Dept. 19 in care of the Journal. m11tfn

PARTNER IN GENERAL PRACTICE WANTED in Green Lake county, town of 5,000. Fifty-bed private hospital. Five grade schools and one high school. No predominant nationalities. Various churches. Main occupations are leather, fur and metal. Contact Dept. 20 in care of the Journal. m11tfn

GENERAL PRACTITIONER and surgeon wishes young physician for partnership agreement in southeastern Wisconsin community of 20,000. Good hospital. Contact Dept. 991 in care of the Journal. m6tfn

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WANTED: INTERNIST, Board certified or eligible for association with young internist in southeastern Wisconsin city of 90,000. Contact Dept. 980 in care of the Journal. m4tfn

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FOR SALE: IN WISCONSIN. General practice, well established, same location 40 years, fully equipped 7-room office. Will take any reasonable offer and finance as you wish. Poor health forces retirement. Contact Dept. 912 in care of the Journal. m4tfn

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WANTED: PHYSICIAN to share a clinic which is now occupied by an M.D. and a D.D.S., located in a prosperous southeastern Wisconsin industrial and farming community where the need for another physician is very great. Contact Dept. 827 in care of the Journal. 4tfn

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FOR SALE: PEDIATRICS PRACTICE in suburb of large Wisconsin city; will introduce; buyer assume two-year lease; open hospital staff; physician leaving Sept. 1, 1962, for academic post. Contact Dept. 985 in care of the Journal. m5tfn

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FOR SALE: G. E. Cardioscribe, Type 1, DWB; hospital surgical instruments; Audiograph dictating machine. Contact Mrs. J. S. Supernaw, 6100 Midwood Avenue, Madison. m11tfn

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WANTED: GENERAL PRACTITIONER. Milwaukee, Wisconsin. General practitioner desires associate. First year, salary; then profit percentage leading to partnership. Contact Dept. 957 in care of the Journal. m12tfn

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WANTED: ONE OR TWO general practitioners and surgeons, singly or a team, to fill void left by death of two physicians. Twenty-seven bed hospital well equipped located in village surrounded by large rural area. No other physicians in community. Contact J. H. Twetan, Iola, Wisconsin. 6tfn

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WANTED: GENERAL PRACTITIONER to become associated with small group in central Wisconsin, preferably one who has had some practical experience, and has a special interest in obstetrics; also willing to only assist in surgery. Contact Dept. 969 in care of the Journal. m2tfn

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WANTED: GENERAL PRACTITIONER as a replacement in town of 1,275 in southern Wisconsin. Gross receipts $42,000 in 1961, over $24,000 first 6 months 1962. Unopposed, good schools, churches, roads, fishing. Nearby accredited 200 bed hospital. Leaving for residency. Contact: D. L. Minter, M.D., Clinton, Wis. m9tfn

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WANTED: GENERAL PRACTITIONER to replace physician who left for residency training. Fully equipped office available immediately. Town of 2,100 offers good hospital, skiing, hunting, golf, fishing and many other recreational advantages along the Chippewa River near its junction with the Mississippi. Financial remuneration should be excellent from the start. Contact Dept. 7 in care of the Journal. m9tfn

---

WANTED: GENERAL PRACTITIONER for associate with two other general practitioners in community of 2,400 with trade area of 7,000. No investment required. Excellent clinical and diagnostic facilities. 200 bed hospital 15 miles. Good educational facilities. Convenient communications to recreational areas. Contact Dept. 8 in care of the Journal. m9tfn

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WANTED: YOUNG GENERAL SURGEON for associate leading to partnership in one year if mutually agreeable. Mideastern Wisconsin. Contact Dept. 9 in care of the Journal. m9tfn

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GOOD LOCATION AVAILABLE for general practitioner. Nothing to buy. Will assist and refer all general practice cases. Contact C. A. Sholtes, M.D., Richland Center, Wis., Midway 7-2592 or 7-2544. m9tfn

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WANTED: GENERAL PRACTITIONER urgently needed to become permanent member of Wisconsin clinic with rapidly expanding medical and surgical practice. Excellent salary arrangement can be offered with early partnership. Contact Dept. 961 in care of the Journal. m8tfn

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WANTED: GENERAL PRACTITIONER to take over practice or partnership in excellent rural community. Open staff hospital. Should net $20,000 first year. Send inquiries to Dept. 17 in care of the Journal. m10-3

FOR SALE: RADIOLOGIST has for sale radiographic and therapy equipment, seven-room office occupied over 40 years in professional building main corner city of 35,000. Southern Wisconsin. Reasonable price. Contact Dept. 988 in care of the Journal. m6tfn

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FOR SALE: GENERAL PRACTICE, well trained and active, in new fully equipped clinic building. Present physician leaving for residency. Personnel well trained and efficient. Rural village 38 miles northeast of Madison. New school, swimming pool, good housing available. Subsidy can be arranged through village. Contact Joseph G. Brown, M. D., Cambria, Wisconsin. m6tfn

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FOR SALE: GENERAL PRACTICE in Chippewa Falls, Wis.; well established, same location for 17 years, fully equipped 5½-room office. Will take any reasonable offer and finance as you wish. Office help available. Practice available because of recent death of William F. Janc, M.D. Contact Mrs. William F. Janc, 300 Macomber Street, Chippewa Falls, Wis. m7tfn

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PHYSICIANS, with or without pediatric training, needed in maternal and child health program at salaries ranging from $9,960.00 to $13,200.00. Five-day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, Milwaukee Health Department, Municipal Building, Milwaukee 2, Wis. g8tfn

---

WANTED: GENERAL PRACTITIONER as associate in a four-man group with adequate clinical facilities. Offer open for two or three year locum tenens or for permanent association in the group. Town of 4,000, well-equipped 80-bed hospital, in west central Wisconsin. Contact Dept. 10 in care of the Journal. m9tfn

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PHYSICIANS WANTED: Psychiatrists, general practitioners, and internist at 1176-bed accredited psychiatric hospital located in good community near Wisconsin vacationland. Good schools and community services. Usual entrance salaries range from $11,150 to $14,565. Five to six per cent increase approved and scheduled for January, 1964. Possible to attain $19,785 annual salary through periodic within-grade increases and advancement in grade. Higher entrance rates for specialists. Excellent fringe benefits include life and health insurance, retirement, vacation and sick leave with pay. Must be graduate of recognized medical school and licensed in one of the United States. Inquire: Aaron S. Mason, M.D., Hospital Director, VA Hospital, Tomah, Wis. 12-2

FOR SALE: INDEPENDENT PRACTICE in internal medicine in Marshfield, Wis., population 15,000, medical center for area of 50-mile radius and 75,000 population. Hospital of 268 beds with 105-bed addition nearly completed. Established in 1956, practice has grossed $75,000 per year for past three years. Excellent records, eight-room suite of offices, laboratory equipment available. Financial arrangements flexible. Contact Mr. Ralph Crain, 800 S. Drake Ave., Marshfield, Wis., phone area code 715, FUlton 4-2915, or C. Bruce Taylor, M.D., Department of Pathology, Evanston Hospital, Evanston, Ill., phone area code 312, UNiversity 9-2500, Ext. 760. m12tfn

ALLERGIST WANTED to share offices with dermatologist. Located in thriving area, south central Wisconsin. Unusual opportunity. Applicant must be board certified or qualified and intending to become certified. Reply, with details of personal and professional qualities and qualifications, to Dept. 5 in care of the Journal. m8tfn

---

WANTED TO RELOCATE: Solo general practitioner in same office over 20 years must yield present location. Prefer to locate in rural area where a GP needs assistance or wishes to retire. Will consider serving in any way compatible and fitting within the sphere of mutual concern. Any inquiries will be held confidential with no expense or obligation. Contact Dept. 18 in care of the Journal. m11tfn

---

WANTED: INTERNIST for newly formed professional corporation in northeastern Wisconsin. Ideal living conditions and superior opportunity for advancement. Salary during first two years of association. Contact Dept. 25 in care of the Journal. 1tfn

---

POSITION WANTED: Anesthesiologist, young, married, personable, Wisconsin-trained physician, now completing anesthesia residency, desires location and association in a progressive community requiring specialty practice July 1963. Contact Dept. 27 in care of the Journal. m1tfn

---

OUTSTANDING OPPORTUNITY for a young physician who is willing to work. Good schools, good 100-bed hospital. Good fishing and hunting. Retiring. Contact Dept. 32 in care of the Journal. m2–3

WANTED: YOUNG GENERAL PRACTITIONER interested in general medicine and obstetrics to associate with a small group in northwestern Wisconsin. Salary arrangement to start with early partnership. Contact Dept. 982 in care of the Journal. 5, 8tfn

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WANTED: Certified or qualified specialist in—

1. Orthopedics
2. ENT
3. Ophthalmology
4. Psychiatry
5. Proctology
6. Pediatrics
7. Neurology
8. Pathology
9. Anesthesiology

to join 26-man, all-specialist group. Contact Robert G. Zach, M.D., The Monroe Clinic, Monroe, Wis. 8tfn

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FOR RENT: OFFICE SPACE, 1200 sq. ft., for medical offices in modern, air-conditioned building at 16 East Gorham Street, Madison. Available for immediate occupancy. Will accommodate one or two physicians, preferably internists. Off-street parking. Contact Robin Allin, M.D., 1313 Fish Hatchery Road, Madison, Wis., phone ALpine 6–5521; or residence CEdar 3–2082. m8tfn

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FOR SALE: Pelton autoclave, model number FL2, like new, $100 ($275 cost). Contact Eugene M. Kay, M.D., 1915 W. Hampton Ave., Milwaukee, Wis. CO 4–2898. m1tfn

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WANTED: GENERAL PRACTITIONER with interest in surgery and obstetrics for physician now grossing over $50,000 and planning retirement within five years. To take over entire practice ultimately and now enter into partnership agreement until final termination of practice occurs. Excellent opportunity, no investment involved, full hospital privileges to qualified person. Large southeastern Wisconsin industrial city. Contact Dept. 13 in care of the Journal. m11tfn

---

WANTED: EXPERIENCED GENERAL PRACTITIONER to join two young GPs, St. Paul, Minn. Progressive, ethical, remunerative practice, three open-staff hospitals, own new building completely equipped. Salary first year leading to partnership; share calls. Excellent family area with good schools. Contact Dept. 22 in care of the Journal. 12–2

FOR SALE: Northwest Chicago general practice. Complete equipment, 2,000 active patients, large annual gross. Nurses remain. Reasonable terms. Contact Dept. 28 in care of the Journal. 1–2

PHYSICIAN WANTED: General practitioner in northeastern Wisconsin wants part time help. Can use one man or combination to cover practice for week, month, or up to a year. Money no object for right man. No OB or surgery unless desired. Living facilities and car available. Contact Dept. 29 in care of the Journal. m1tfn

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WANTED: METAL HAMILTON TABLE, recent model, in good condition. Contact Dept. 30 in care of the Journal. m1tfn

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WANTED: PHYSICIAN for Wisconsin State Prison at Waupun, Wis. Eight-hour day, five-day week, retirement, civil service benefits. No office to maintain, no bills to collect, no obstetric cases. Beginning salary $10,596 to $14,196 depending upon qualifications. Salary can go to $17,796 per year. Write John C. Burke, Warden, Wisconsin State Prison, Waupun, Wis. 1–3

WANTED: PHYSICIAN to associate with two established general practitioners in southeastern Wisconsin industrial, agricultural community of 6,000. Prefer one who has had special surgical training and willing to do general practice along with surgery. Contact Dept. 31 in care of the Journal. m1–3

PRIME OPPORTUNITY for additional doctor in vigorous group of seven in general practice. County seat town of 6,000, new building with excellent x-ray, laboratory, other facilities. 60-bed municipal hospital in town JCAH accredited. Seeking man from internship, or with additional training medical or surgical, or man finishing service commitment. Excellent opportunity development one or several fields. Salary at outset, then increasing percentage to full partnership. Inquire Cantwell–Peterson Clinic, Shawano, Wis. 12–2

INTERNIST WANTED: Fourteen-man Iowa group has opening for Board qualified internist. City of 30,000, new clinic building, complete laboratory and x-ray. Partnership in two years; salary open. Contact Dept. 26 in care of the Journal. 1–3

COMMERCIAL

WANTED: Advertisements for this new section. Open for physicians, individuals, firms, organizations who have something they would like to sell, or are looking for something to buy, or have a service available, which might be of interest to physicians.

INDEX TO ADVERTISERS

	Page
Abbott Laboratories	69, 70
Ames Company, The	71
Barr X-ray Co., The	44
Benson Optical Company	15
Borden's	63
Bristol Laboratories	16, 17
Burroughs Wellcome & Co., Inc.	22, 28
Coca Cola Company, The	4
Davies, Rose & Company, Ltd.	41
Haug Drug Company	18, 38
Hotel Schroeder	44
House of Bidwell, Inc.	44
Hurley X-ray Company	49
Keeley Institute, The	44
Lederle Laboratories	24, 25, 30, 31, 35
Leeming, Thos. & Co., Inc.	13
Lilly and Company, Eli	Front cover, 36
Medical Protective Company, The	38
Milwaukee Sanitarium Foundation	63
National Guardian Life Insurance Co.	61
Parke, Davis & Company	2, 3
Pfizer Laboratories	58, 59
Physicians' Exchange	65
Physicians Mutual Insurance Co.	44
Poythress, Wm. P. & Co., Inc.	26, 56
Rennebohm's	63
Robins Co., Inc., A. H.	19, 20, 21, 62
Roche Laboratories	Back cover
Roerig & Co., J. B.	54, 55
Rogers Memorial Hospital	18
Sacred Heart Sanitarium	49
St. Croixdale Sanitarium	4
Saunders Company, W. B.	11
Searle & Co., G. D.	37
Shorewood Sanitarium	42
Smith, Kline & French Laboratories	23
Time Insurance Company	8
Wallace Laboratories	12, 29, 33
Winthrop Laboratories	14, 27, 32
Wisconsin Physicians Service	34

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Vol. 62, No. 3—MARCH 1963

STATE MEDICAL SOCIETY OF WISCONSIN
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Contents

SCIENTIFIC ARTICLES

Page

Brain Stem Vascular Accident Following Neck Manipulation; case report, by Robert A. Pribek, M.D., La Crosse ---- 141

Vascular Ring Anomalies, by George G. Griese, M.D. and Ben R. Lawton, M.D., Marshfield ---- 145

Torsion of the Gallbladder; case report, by John T. Sullivan, Jr., M.D., F.A.C.S. and Keith B. Appleby, M.D., Milwaukee ---- 149

Clinicopathologic Conference, by James L. Jaeck, M.D., Sheboygan ---- 152

SPECIAL FEATURES

Family Life Education for High School Youth, by W. O. Brown, Madison ---- 143

Comments on Treatment: Treatment of Poisoning Due to Alkylphosphate Cholinesterase Inhibitors, by James L. Way, Ph.D., Milwaukee ---- 157

Salmonellosis (abstract) ---- 158

Treatment of Frostbite (abstract) ---- 158

Page

Conference on Health Fads and Fallacies ---- 162

1963 SMS Annual Meeting Program ---- 163

Official Notice: Amendments to the Constitution Introduced at 1962 Session of House of Delegates and to be Acted Upon by 1963 House of Delegates in May ---- 54

EDITORIALS

President's Page: Sincerely Yours, by N. A. Hill, M.D., Madison ---- 159

Pandemic Predicament ---- 160

Off the Floor for '64 ---- 161

REGULAR FEATURES

Obituaries ---- 35

Calendar of Meetings ---- 45

Medical Meetings—Postgraduate Courses ---- 45

Facts about Wisconsin Physicians Service ---- 52

Physicians Exchange ---- 55

Index to Advertisers ---- 58

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Journal
Established 1903

Annual Subscription ---- $6.00
Single Copy ---- 1.00
Previous Years' ---- 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 303 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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Dr. George E. Whalen, retired Milwaukee physician, died December 23, 1961, at the age of 70.

Born on August 11, 1891, at Appleton, Doctor Whalen was a 1916 graduate of Marquette University School of Medicine. A specialist in internal medicine, Doctor Whalen practiced in Milwaukee until 1960 when he retired.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association.

Surviving is his widow, Rosalie; one son, George E. Whalen, Jr., M. D., Brookfield; and two daughters, Mrs. Thomas C. Kurth, Chenequa, Wisconsin, and Norine, Milwaukee.

Dr. Hubert J. Haubrick, a general practitioner in Oshkosh, died February 14, 1962, at the age of 88.

Doctor Haubrick was born in St. Peters, Wisconsin, on December 13, 1873. He graduated from Marquette University School of Medicine in 1903 and completed his internship at St. Vincent's Hospital in Green Bay in 1903.

He was a past president and member of the Fond du Lac County Medical Society, and was a member of the State Medical Society of Wisconsin and the American Medical Association.

Surviving is his widow, Anna.

Dr. Harold M. Coon, 66, superintendent of Milwaukee County General hospital and former superintendant of University Hospitals, Madison, died February 28, 1962.

Doctor Coon was born in Milwaukee on June 29, 1895. He received his medical degree from the University of Pennsylvania Medical School in 1922, and interned at University Hospitals, Madison, from 1922–23. He practiced at Stevens Point from 1923 until 1937; Wales, Wisconsin, from 1937 until 1941; Madison, from 1941 to 1956; and Milwaukee, from 1956 until the time of his death.

He was a past president of the Portage County Medical Society and member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin and the American Medical Association. He was a diplomate of the American Board of Internal Medicine, a fellow of the American College of Physicians, member of the American Hospital Association and on its board of trustees, and member and past president of the Wisconsin Hospital Association. He was also a member of the American Trudeau Society, American College of Hospital Administrators, a fellow of the National Tuberculosis Association, a past president of the Mississippi Valley Conference on Tuberculosis, was chairman of the State Board of Health's tuberculosis advisory committee, and a member of the State Department of Adult and Vocational Education's advisory board. In 1955 he was honored by the Wisconsin Hospital Association for his "efforts to improve hospital service" throughout the state.

Survivors include his widow, Mary.

Obituaries

Dr. Max A. Grossman, 53, a urologist at Green Bay, died March 1, 1962.

Born on October 24, 1908, at Denver, Colorado, Doctor Grossman graduated from the University of Wisconsin Medical School in 1936. He interned at St. Louis Jewish Hospital, St. Louis, Missouri, from 1936 to 1937 and completed his residency training at Morrisania City Hospital in New York from 1937 to 1940.

He was a member of the Brown County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He was also a member of the Wisconsin Urological Society.

Surviving is his widow, Katherine; and two daughters, Linda and Marion.

Dr. Samuel G. Schwarz, a retired general practitioner. died March 4, 1962, at the age of 89, in Black River Falls.

Born in Germany on April 28, 1872, Doctor Schwarz was graduated from the Milwaukee Medical College in 1900. He practiced medicine in Milwaukee, Granton, Humbird, and Marshfield.

He was a former member of the Clark County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Surviving is his son, Robert, of Wilmette, Illinois.

Dr. William H. Dushack, Sun Prairie, died March 6, 1962, at the age of 36.

Doctor Dushack was born February 14, 1926, in Sun Prairie. He was a graduate of the University of Wisconsin Medical School in 1955. He interned at Milwaukee Hospital from 1955 to 1956.

He is survived by his mother, Mrs. Albert Dushack.

Dr. Else M. Knudsen, a physician and surgeon at Iola, died March 31, 1962, at the age of 52.

She was born at Copenhagen, Denmark, on March 24, 1910, and graduated from the University of Copenhagen Medical School in 1940. She interned at State Hospital, Sonderborg, Denmark, from 1940 to 1941, and completed a residency there from 1941 through 1947. She practiced in Denmark from 1947 to 1953 when she came to the United States. After a year of internship at Mercy Hospital in Oshkosh from 1953 through 1954, she located in Iola where she practiced until the time of her death.

She was a member of the Waupaca County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Survivors include her husband, Lau; one son, Soren, and one daughter, Signe, Scandinavia.

OBITUARIES *continued*

Dr. John R. Venning, former Fort Atkinson city health officer, died April 1, 1962, at the age of 80.

Doctor Venning was born at Dodgeville on March 15, 1882, and received his medical degree from Eclectic Medical College, Cincinnati, Ohio. He practiced medicine in Arkansas and Nebraska before coming to Wisconsin. He served Fort Atkinson as city health officer from 1925 to 1961 when he retired.

He was a member and past president of the Jefferson County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He was also a past president of the Wisconsin State Board of Medical Examiners.

Surviving are his widow, Jessie; one daughter, Mrs. Edward Mitchell, Marshfield; and one son, John M., Arlington Heights, Illinois.

Dr. Ralph H. Wiley, general practitioner in Iola, died April 2, 1962, at the age of 45.

Born at Amityville, Long Island, N. Y. on October 22, 1916, Doctor Wiley graduated from Marquette University School of Medicine in 1945. He interned at St. Luke's Children's Hospital in Milwaukee from 1945 to 1946 and completed his residency from 1947 to 1948. He practiced in Iola from 1948 until the time of his death.

Doctor Wiley was a member of the Waupaca County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Survivors include his widow and three children.

Dr. Willis L. Johnson, an eye, nose and throat specialist in Janesville for over 40 years, died April 3, 1962, at the age of 70.

Doctor Johnson was born at Delano, Minnesota, on July 4, 1891, and graduated from Rush Medical College, Chicago, Illinois, in 1918. He interned at Michael Reese Hospital in Chicago from 1918 until 1919, and began his practice in Janesville in 1921. He completed his residency at the New York Postgraduate School from 1922 until 1923 and then returned to Janesville where he practiced until the time of his death.

He was a member of the Rock County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Survivors include his widow, Elsie; one son, Philip, Madison; one daughter, Mrs. Marvin Kagan, Appleton.

Dr. Frank D. Weeks, 58, physician and surgeon at Ashland for nearly 30 years, died April 3, 1962.

Born at Marion, Ohio, on October 20, 1903, Doctor Weeks graduated from the University of Wisconsin Medical School in 1928. He interned at Kansas City General Hospital from 1928 through 1929 and returned to University Hospitals in Madison for a residency in surgery from 1930 through 1933.

During World War II he served in the U. S. Army Medical Corps including two years in the South and Central Pacific. He then returned to Ashland where he continued his practice until the time of his death. He helped organize the Smiles–Prentice Medical Group in Ashland.

Doctor Weeks was a member of the Ashland–Bayfield–Iron County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He was a diplomate of the American Board of Surgery, a fellow of the American College of Surgeons, member and past president of the Wisconsin Surgical Society, a member of the Wisconsin Surgical Club and the American Association of Railway Surgeons. He also served on the Editorial Board of the *Wisconsin Medical Journal.*

Survivors include his widow, Frances; two daughters, Mrs. Donald Walker, Milwaukee; and Martha; and one son, Douglas; and one brother, Dr. O. Douglas Weeks, Austin, Texas.

Dr. Matthew W. Biljan, West Allis, a general practioner, died April 12, 1962, at the age of 50.

Doctor Biljan was born in Phillips in 1912. He was a 1937 graduate of Northwestern University Medical School, Evanston, Illinois, and interned at Deaconess Hospital in Milwaukee from 1937 to 1938. He practiced in West Allis from 1938 until the time of his death.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association.

Surviving are his widow, Grace; and a son, William, Wauwatosa.

Dr. David F. Cole, Ripon physician and surgeon for 31 years, died April 18, 1962, at Fond du Lac.

Born on October 10, 1905, at Reedsburg, Doctor Cole obtained his medical degree from the University of Wisconsin in 1931; he interned at Oklahoma General Hospital from 1931 to 1932.

Doctor Cole was a member of the Fond du Lac County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Survivors are his widow, Dorothy; a daughter, Beverly; and a son, Bruce, all of Kalamazoo, Michigan; and his mother, Mrs. Ida Cole, Reedsburg.

Dr. Seth R. Medley, retired physician at Spooner, died April 25, 1962, at his home at the age of 74.

Born on November 18, 1887, in Sextonville, Wisconsin, Doctor Medley received his medical degree from the University of Oklahoma. A veteran of World War I, Doctor Medley began practice in Butler, Oklahoma, and later went to Siren and Shell Lake before setting up practice in Spooner where he practiced from 1930 to 1961 when he retired.

Doctor Medley was a former member of the Barron–Washburn–Sawyer–Burnett County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

Surviving are his widow, May; and four children, Donald, Riverside, California; Mrs. Shirley Drinkwater, Alameda, California; Lawrence, Waukegan, Illinois; and Robert, Chicago, Illinois.

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OBITUARIES *continued*

Dr. Cecil B. Hake, a Milwaukee physician for over 50 years died April 29, 1962, at the age of 75.

A native of Milwaukee, Doctor Hake was born November 13, 1886. He was a 1911 graduate of Marquette University School of Medicine and interned at Luther Hospital in St. Paul, Minnesota, from 1911 through 1912. He practiced medicine in Milwaukee from 1912 until the time of his death.

He was a member of the Fifty-Year Club of the State Medical Society of Wisconsin and a member of The Medical Society of Milwaukee County and the American Medical Association.

Surviving are his widow, Marie, and a son, William, Milwaukee.

Dr. Edward T. Lautenbach, 56, a former Brandon physician, died April 30, 1962.

Born on April 1, 1906, at Plymouth, Wisconsin, Doctor Lautenbach graduated from Marquette University School of Medicine in 1934 and interned at St. Mary's Hospital, Milwaukee, from 1933 to 1934. He practiced previously at Platteville, St. Cloud, and Plymouth before moving to Brandon where he practiced from 1943 until 1960 when he became a member of the medical staff of Waupun State Prison.

He was a member of the Fond du Lac County Medical Society, the State Medical Society of Wisconsin and the American Medical Association. He was also a member of the American Academy of General Practice.

Survivors include his widow, Jane; two daughters, Mary of St. Paul, Minnesota; and Anne of Milwaukee; and a son, James, of Brandon.

Dr. John W. Truitt, past president of the State Medical Society of Wisconsin, died May 1, 1962, at Fort Lauderdale, Florida, at the age of 68.

Born at Naperville, Illinois, on February 12, 1894, Doctor Truitt was a 1920 graduate of Northwestern University Medical School, Evanston. He interned at Columbia Hospital in Milwaukee. A specialist in eye, ear, nose and throat, Doctor Truitt practiced in Wauwatosa from 1922 until 1956 when he retired, taking up residence in Fort Lauderdale.

Being a former member of The Medical Society of Milwaukee County as well as the State Medical Society of Wisconsin and the American Medical Association, Doctor Truitt was past president of the State Society, a member of its Council and a delegate for The Medical Society of Milwaukee County. He was a fellow of the American Board of Ophthalmology and Otolaryngology, a past president of the Milwaukee Society of Ophthalmology and Otolaryngology and a life member of the American College of Surgeons and the American Academy of Eye, Ear, Nose and Throat.

Survivors include his widow, Helen; one son, Robert B. Truitt, M. D.; and one daughter, Mrs. Adrienne Werner.

Dr. Charles F. Ulrich, Kenosha, a specialist in internal medicine, died May 7, 1962, at the age of 74.

Born on May 14, 1889, Doctor Ulrich was a 1916 graduate of Creighton University Medical School, Omaha, Nebraska. He interned at St. Joseph's Hospital in Omaha from 1916 through 1917. After practicing in Valentine, Nebraska, for five years, he took further study in internal medicine at the University of Pennsylvania. He then returned to Omaha to resume his practice until 1929 when he moved to Kenosha where he stayed until the time of his death.

Doctor Ulrich was a past president and secretary of the Kenosha County Medical Society and a member of the State Medical Society of Wisconsin and the American Medical Association.

Surviving is his widow, Rose; one son, Charles F. Jr., Kenosha; and three daughters, Mrs. Arthur Priebe, Tunjunga, California; Mrs. John Stracke, Sturtevant; and Mrs. Thomas Copeman, Jr., Chula Vista, California.

Dr. Reynold O. Bassuener, 61, died May 18, 1962, at Milwaukee.

A native of Sheboygan, Doctor Bassuener obtained his medical degree from Rush Medical School in Chicago, Illinois, in 1927. He completed his internship at Milwaukee Hospital and Milwaukee Children's Hospital. At the time of his death, he was the medical director of Johnston Municipal Hospital, a position he had held for 18 years.

Doctor Bassuener was a former member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association.

Survivors include his widow, Margaret; one son, David, Beloit; and one daughter, Nancy, Sioux City, Iowa.

Dr. Francis H. Kelley, Merrill physician for 57 years, died May 22, 1962, at the age of 83.

Born at Winfield, Wisconsin, on November 4, 1878, Doctor Kelley was a 1905 graduate of Milwaukee Medical College, now Marquette. After interning one year at Trinity Hospital, Milwaukee, he practiced at Merrill until the time of his death.

A member and past president of the Lincoln County Medical Society, Doctor Kelley was also a member of the Fifty–Year Club of the State Medical Society of Wisconsin and a member of the American Medical Association.

Surviving is one son, James, executive secretary of The Medical Society of Milwaukee County; and three daughters, Mrs. Leonard Donoghue, Merrill; Mrs. Paul Justus, Upper Heyford, Oxford, England; and Pat, Merrill.

Dr. Herbert E. Froede, Silver Spring, Maryland, a former Milwaukee physician, died June 13, 1962, at the age of 67.

Doctor Froede was born in Milwaukee on April 28, 1895. In 1926 he graduated from Marquette University School of Medicine, and completed his in-

ternship at Milwaukee County Hospital from 1925 until 1926. He practiced in Milwaukee and Jackson, Wisconsin. He was associated with the Veterans Administration in Washington, D. C.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association.

He is survived by his widow, Helen.

Dr. Fred B. Welch, 78, health commissioner of Janesville for 43 years, died July 9, 1962.

Born at Janesville on October 17, 1883, Doctor Welch graduated from Northwestern University Medical School in 1908. He interned at Oak Park Hospital, Chicago, Illinois, from 1908 to 1909. From 1908 to 1936 he served Janesville as part-time health officer while engaged in private practice. From 1936 until the time of his death he was a full-time health commissioner and developed the Janesville Health Department.

He was a member of the Rock County Medical Society, a member of the Fifty-Year Club and a life member of the State Medical Society of Wisconsin and a member of the American Medical Association. He was a former president of the Wisconsin Association of Food and Sanitation Officials, the Illinois–Wisconsin Dairy Technology Society and the Lakeshore and Southeast Wisconsin Health Officer and Food Handler Association. A fellow of the American Public Health Association and an honorary member of the National Association of Sanitarians, he was a charter member of the Association of Public Health Physicians.

Surviving is his widow, Elsi; and a daughter, Mrs. Helen Parris, Olivia, Minnesota.

Dr. Rolland G. Raymond, a general practitioner at Brownsville for 40 years, died July 14, 1962, at the age of 81.

Doctor Raymond was born in Campbellsport, February 27, 1881. He was a graduate of the Wisconsin College of Physicians and Surgeons in Milwaukee in 1906, and interned at St. Joseph's Hospital in that city in 1906. He had practiced since that time in Brownsville, retiring in 1946.

Doctor Raymond was a member of the Fifty-Year Club and a life member of the State Medical Society of Wisconsin as well as being a member of the Fond du Lac County Medical Society and the American Medical Association.

Dr. Harry J. Zurheide, Elm Grove, died July 23, 1962, at the age of 39, after a long illness.

Doctor Zurheide was born in Milwaukee. He was a 1949 graduate of the University of Wisconsin Medical School and served his internship at Milwaukee Hospital. After completing his military service in 1954, Doctor Zurheide joined his father, Dr. Harry O. Zurheide, in general practice at Elm Grove.

He was a member of the Waukesha County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Maryann; and two sons, Alan and Carl, at home.

Dr. Leon H. Guerin, Milwaukee eye, ear, nose and throat specialist, died August 28, 1962, at the age of 62.

A native of Wisconsin, Doctor Guerin was born in Washburn, and was a 1927 graduate of Marquette University School of Medicine. He interned at Milwaukee Hospital and served his residency at North Chicago hospital before establishing his practice in Milwaukee in 1929. In recent years, Doctor Guerin had limited his practice to ophthalmology.

Doctor Guerin was a member of the American Academy of Ophthalmology, the Milwaukee Oto-Ophthalmic Society, The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Thelma; a daughter, Mrs. Elizabeth O'Reilly, Bayside; and a son, William L., Mequon.

Dr. Edward B. Jacobson, a Milwaukee physician, died October 16, 1962, at the age of 66.

A native of Latvia, Doctor Jacobson graduated from the Marquette University School of Medicine in 1922. He served his internship at Milwaukee County Hospital, and had spent the past 40 years in Milwaukee engaged in the specialty practice of urology.

Doctor Jacobson was a member of the Milwaukee Urological Society, Wisconsin Urological Society, The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

He is survived by his widow and two children.

Dr. Thomas L. Tolan, retired Milwaukee ear, nose and throat specialist, died October 21, 1962, at the age of 70.

Born in Ironwood, Michigan, Doctor Tolan was a 1918 graduate of the University of Michigan Medical School. He interned and completed his residency at the University of Michigan before establishing his practice in Milwaukee in 1921.

Active in state medical society affairs, Doctor Tolan was a member of the first State Medical Society's Committee on Hearing Defects established in 1945, and served as chairman of the Committee from 1950 to 1953. He served as president of the American Hearing Society for three years, and was also a Board member and Chairman of the Milwaukee Hearing Society.

He was a member of the American Academy of Ophthalmology and Otolaryngology, American Rhinological, Otological and Laryngological Society; the American Otological Society; and an associate member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Doctor Tolan is survived by his widow, Alice; and a son, T. L. Tolan, Jr., Milwaukee.

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CALENDAR OF MEETINGS

1963 **Wisconsin**

Apr. 3: Symposium on Alcoholism, Northwest Psychiatric Clinic, Eau Claire.

April 3–5: Seminar on Bobath Approach to the Treatment of Cerebral Palsy, Central Wisconsin Colony and Training School, Madison.

April 18: SMS teaching program on Clinical Electrocardiography, Mercy Hospital, Oshkosh.

April 18–19: Annual meeting, Wisconsin Anti-Tuberculosis Association, Pfister Hotel, Milwaukee.

Apr. 18–20: Health Fads and Fallacies symposium, State Medical Society headquarters, Madison.

April 25–27: Postgraduate course on Renal Diseases in Childhood, University of Wisconsin Medical Center, Madison.

May 6–9: State Medical Society of Wisconsin annual meeting, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

May 11–12: Joint meeting of the Wisconsin, Illinois, and Iowa Associations of Blood Banks, Nippersink Manor, Genoa City.

1963 **Out-of-State**

Apr. 1–4: Fifteenth Annual Scientific Assembly of American Academy of General Practice, new McCormick Place, Chicago.

Apr. 1–5: 44th Annual Session of American College of Physicians, Denver, Colo.

May 24–25: Annual clinical conference of The Chicago Ophthalmological Society, Drake Hotel, Chicago.

June 10–13: Convention of the Catholic Hospital Association of the United States and Canada, Conrad Hilton Hotel, Chicago.

July 15–19: Second International Conference on Congenital Malformations sponsored by The National Foundation–March of Dimes, Americana Hotel, New York City.

Aug. 26: Annual meeting of American Academy of Physical Medicine and Rehabilitation, Sheraton–Dallas Hotel, Dallas, Tex.

Oct. 21–22: 1963 Scientific Session of American Cancer Society—A conference on "Unusual Forms and Aspects of Cancer in Man", Biltmore Hotel, New York City.

Nov. 5–13: Ninth Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Nov. 13–Dec. 10: First Pan-Pacific Mobile Educational Lecture Seminar, New Zealand, Australia, Thailand, the Philippines, Hong Kong and Japan.

MEMBERS INVITED TO STATE DENTAL SOCIETY MEETING

Members of the State Medical Society of Wisconsin are invited by Dr. L. O. Skaalen, president of the Wisconsin State Dental Society, to attend the scientific program of the Society's 93rd Annual Session at the Milwaukee Auditorium, April 29–May 1. The theme of this year's program will be: "Program for Progress: Research, Education, Care." Guest badges allowing admittance to the meeting may be obtained in the registration area at the Kilbourn Avenue entrance. The only identification needed is your current medical society membership card.

Medical Meetings
Postgraduate Courses

Wisconsin Nurses Association

"Professionally Yours" is the title of the Legal Aspects Institute which the Wisconsin Nurses Association will conduct at the Dell View Hotel at Lake Delton, near Wisconsin Dells, on Thursday and Friday, April 25 and 26.

Mrs. Katherine B. Wolfe, R.N., who was with the University of Wisconsin School of Nursing in 1961 and 1962 to conduct a special study of nursing in Wisconsin, will give the keynote address Thursday afternoon on "What is Professional Nursing Practice?" Mrs. Wolfe is chief of nursing service for the Veterans Administration Area Medical Office, Trenton, New Jersey.

Sponsoring WNA committees for the institute are those on Education and Professional Nursing Practice. The nurses emphasize that doctors, hospital administrators, and nursing home administrators are welcome to attend.

While this institute will interpret legal aspects of nursing, major focus will be on what professional nursing practice is and ways and means of coping with the problems encountered in everyday practice.

The Thursday evening meeting will be titled "Medications—Who Dispenses? Who Administers?", and will include demonstration of equipment and discussion of methods of dispensing and administration medications.

Presenting this program will be Mr. Paul A. Pumpian, secretary of the State Board of Pharmacy, and Mrs. Elaine F. Ellibee, R.N., director of nursing service and education, Central Wisconsin Colony.

Mr. James McDermott, assistant state attorney general, will address the group Friday morning on "Implications for the Professional Nurse of Medical and Nursing Practice Acts."

Information on institute or hotel reservations can be obtained at your nearest hospital or by writing the Wisconsin Nurses Association, 161 W. Wisconsin Ave., Milwaukee.

Southern Medical Association

The Section of Ophthalmology and Otolaryngology of The Southern Medical Association announces that its next meeting will be held in New Orleans, La., Nov. 18 to 21.

Papers will be accepted for consideration up to May 15, 1963. A title and brief abstract of 75 words or less should be sent as soon as possible to Dr. Albert C. Esposito, Secretary, Southern Medical Association, 1212 First National Bank Building, Huntington, W. Va.

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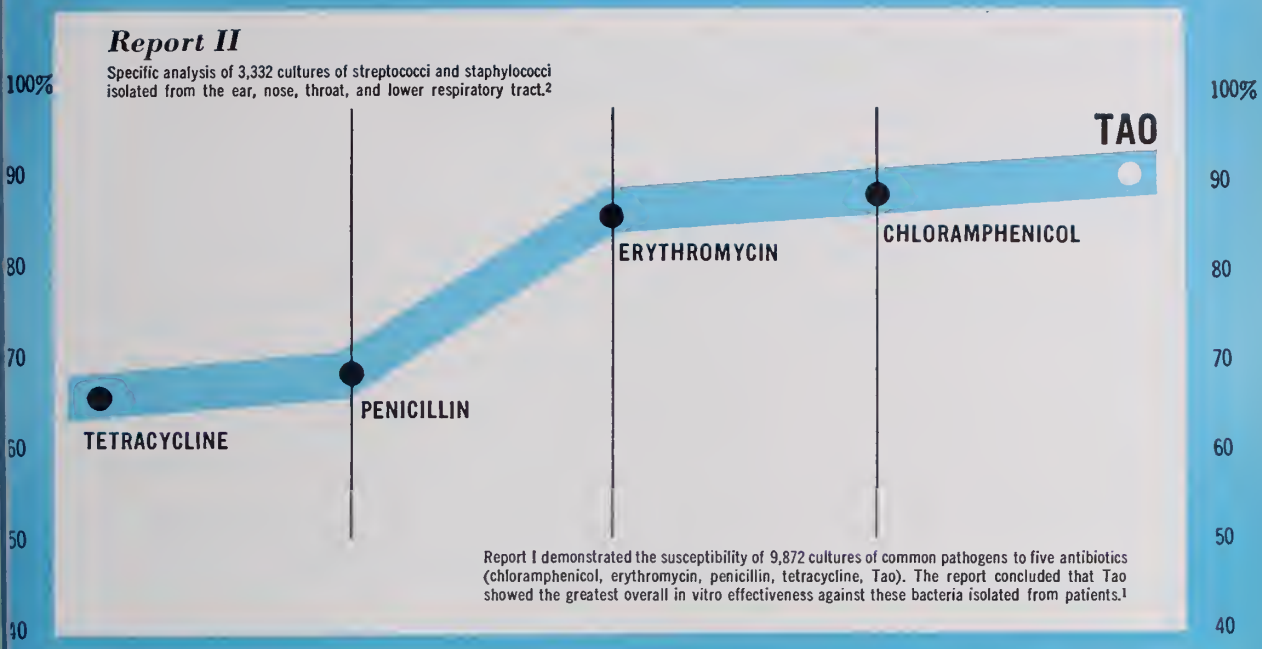

Report II

Results of Bacterial Susceptibility in 3,332 Respiratory Pathogens

References

1. "Bacterial Susceptibility Patterns: A Geographic Survey." Fowler, J. Ralph, M.D., and Watters, John L., M.D. Scientific Exhibit presented at the Annual Meeting of the American Society of Clinical Pathologists, Chicago, Ill., August 31 to September 9, 1962. 2. Fowler, J. Ralph, Watters, John L. and Levy, Arthur M.: Bacterial Susceptibility Patterns as Related to Geographic Variation and Anatomical Source. In press. 3. English, A. R., and Fink, F. C.: Antibiot. & Chemother. 8:420 (Aug.) 1958. 4. English, A. R., and Fink, F. C.: Antibiot. and Chemother. 11:648 (Oct.) 1961.

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OFFICIAL NOTICE

TO MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Pursuant to the requirements of the Constitution and Bylaws of the State Medical Society of Wisconsin, the following amendments to the Constitution, as introduced at the 1962 session of the House of Delegates, are being published in the March and April, 1963, issues of the *Wisconsin Medical Journal.*

Constitutional Amendments Introduced in May 1962 for action in May 1963

Note: Material to be deleted is in parentheses; new material is in italic. The Constitution and Bylaws were published on pp. 57–64 of the January 1963 Blue Book issue of the *Wisconsin Medical Journal.*

Amend Article VI of the Constitution as follows:

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The (president, the) president-elect, the secretary, *and* the treasurer (and the speaker of the House of Delegates) shall be ex officio members of the Council, but without the right to vote, *and the president and speaker of the House of Delegates shall be ex officio members with such right to vote.* (Nine) *A majority* of its *voting* members shall constitute a quorum.

Amend Section 1 of Article IX of the Constitution by addition of the following paragraph:

No person shall hold more than one of such offices concurrently.

Amend the first paragraph of Section 2 of Article IX of the Constitution as follows:

The officers, except the councilors *and the speaker of the House of Delegates,* shall be elected annually. *The term of the speaker shall be for two years.* The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

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Advertisements in this section are accepted in two categories: PHYSICIANS' EXCHANGE and COMMERCIAL.

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DEADLINE: Copy must be received by the 15th of the month preceding month of issue. Send copy to: Wiscansin Medical Journal, Box 1109, Madison 1, Wis.; or phone Alpine 6–3101.

PHYSICIANS' EXCHANGE: This section is limited to physicians and athers desiring physician placement, sale af medical practice or equipment of o physicion, sale or lease af medical buildings, etc. Advertisements from individual members of the State Medical Saciety of Wisconsin are accepted without charge. Widows of deceased member physicions are allowed to odvertise without charge. The rates quoted above opply to ads ploced by clinics ond others. There is na additional charge for ads with Dept. numbers. For these ads, address replies to: Dept. ___, % Wisconsin Medicol Journal, Box 1109, Madisan 1, Wis. Advertisers using Dept. numbers forbid the disclosure of their identity. All inquiries are forwarded to them immediately.

COMMERCIAL: Advertisements are accepted at the obove rates from individuals, firms, organizations, etc., who are reputable, have o good credit rating and advertise products or services of ethical stondards. The Journal reserves the right to reject any advertising. Advertisements fram member physicians are alsa accepted ot the above rates.

PHYSICIANS' EXCHANGE

WANTED: PHYSICIAN AND SURGEON in Bottineau, North Dakota. Very good town, and larger practicing territory to draw from. Sigurd Sigurdson, Bottineau, N. D. p1–3

WANTED: PSYCHIATRISTS or young doctors, interested in psychiatry to work at Mendota State Hospital. These positions are permanent and under Civil Service; salary depends upon previous experience and training. Housing available on grounds. Contact W. J. Urben, M.D., Superintendent, Madison 4, Wis. g10tfn

FOR SALE: UNOPPOSED small town general practice, southwestern Wisconsin. Modern, well equipped, air conditioned building, excellent open staff hospital nearby. Annual gross over $50,000. Contact Dept. 999 in care of the Journal. m8tfn

WANTED: ASSOCIATE IN GENERAL PRACTICE. Established practice in Minocqua resort area which is showing rapid growth, boasts good grammar schools and three-year-old million dollar high school, 20-bed hospital with open staff and nearly completed new addition which will double bed capacity. Own clinic building which consists of waiting room, business office, five examining rooms, laboratory. Salary for first year $1,000 per month. Second year salary plus percentage of gross. Partnership at five years. Start now. Contact Dept. 997 in care of the Journal. m7tfn

FOR SALE: Two level home and office on bank of river; 45-acre estate near town of 6,000, 70 miles north of Madison. Hospital, good schools, several churches. Man with surgical training desirable. Purchase may be made by land contract. Might consider a locum tenens with potential permanent arrangement. A highly flexible opportunity for the right person. Contact Dept. 23 in care of the Journal. m12tfn

WANTED: GENERAL PRACTITIONER as associate. Immediately available opportunity to practice in well established group of two. Replacement for sudden loss of partner. Eventual partnership. 126 E. Main Street, Madison. AL 6–3171. m9tfn

FOR SALE: GENERAL PRACTICE in small town in Wisconsin. Will introduce and accept reasonable offer. Contact Dept. 14 in care of the Journal. m10tfn

URGENTLY NEEDED: General practitioner for association with three physicians, to start as soon as possible. Central Wisconsin city. Salary—the going rate—with $1,000 per month minimum, and partnership as soon as mutually desired. Contact Dept. 984 in care of the Journal. m5tfn

POSITION WANTED: RADIOLOGIST, Board eligible, University training in diagnosis and therapy, hospital and private practice experience, desires position with hospital or association. Contact Dept. 995 in care of the Journal m7tfn

POSITION WANTED: RADIOLOGIST, certified, seeks position preferably in solo practice. Experienced, University-trained. Contact Dept. 979 in care of the Journal. 4tfn

FOR SALE: Established EENT practice, over 40 years in the heart of Milwaukee. Excellent referrals; will introduce; retiring. Contact Dept. 24 care of the Journal. m12tfn

OFFICE SPACE for two or three physicians, OB or two surgeons. To rent or to sell. Pharmacy in same building. Contact Dept. 33 in care of the Journal. m3tfn

WANTED: INTERNIST, Board certified, to join two established surgeons. Excellent office facilities. Opposite 300-bed hospital—200-bed added expansion in progress. Town of 15,000. Central Wisconsin. Guaranteed salary. Percentage and partnership early prospects. Contact Paul F. Doege Medical Center, 512 St. Joseph Ave., Marshfield, Wis. m3tfm

WANTED: GENERAL PRACTITIONER to associate with two young general practitioners in established three-man clinic, located in west central Wisconsin. Excellent new facilities built to handle growing practice. Hospital and recreational facilities excellent. Early partnership for right man. Contact Dept. 996 in care of the Journal. m7tfn

WANTED: PEDIATRICIAN for newly organized group in Fox River Valley of Wisconsin. One other pediatrician in community of 45,000. Excellent living conditions, noted recreational area and above average opportunity. Salary two years, then partnership. Contact Dept. 6 in care of the Journal. m9tfn

GENERAL PRACTICE FOR SALE. Physician desiring own x-ray equipment may purchase radiographic, fluoroscopic and therapy equipment. Seven-room office on main corner in southern Wisconsin city of 35,000 occupied for over 40 years. Wish to retire. Reasonable price. Contact Dept. 19 in care of the Journal. m11tfn

PARTNER IN GENERAL PRACTICE WANTED in Green Lake county, town of 5,000. Fifty-bed private hospital. Five grade schools and one high school. No predominant nationalities. Various churches. Main occupations are leather, fur and metal. Contact Dept. 20 in care of the Journal. m11tfn

GENERAL PRACTITIONER and surgeon wishes young physician for partnership agreement in southeastern Wisconsin community of 20,000. Good hospital. Contact Dept. 991 in care of the Journal. m6tfn

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WANTED: INTERNIST, Board certified or eligible for association with young internist in southeastern Wisconsin city of 90,000. Contact Dept. 980 in care of the Journal. m4tfn

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FOR SALE: IN WISCONSIN. General practice, well established, same location 40 years, fully equipped 7-room office. Will take any reasonable offer and finance as you wish. Poor health forces retirement. Contact Dept. 912 in care of the Journal. m4tfn

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WANTED: PHYSICIAN to share a clinic which is now occupied by an M.D. and a D.D.S., located in a prosperous southeastern Wisconsin industrial and farming community where the need for another physician is very great. Contact Dept. 827 in care of the Journal. 4tfn

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FOR SALE: PEDIATRICS PRACTICE in suburb of large Wisconsin city; will introduce; buyer assume two-year lease; open hospital staff; physician leaving Sept. 1, 1962, for academic post. Contact Dept. 985 in care of the Journal. m5tfn

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FOR SALE: G. E. Cardioscribe, Type 1, DWB; hospital surgical instruments; Audiograph dictating machine. Contact Mrs. J. S. Supernaw, 6100 Midwood Avenue, Madison. m11tfn

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WANTED: GENERAL PRACTITIONER. Milwaukee, Wisconsin. General practitioner desires associate. First year, salary; then profit percentage leading to partnership. Contact Dept. 957 in care of the Journal. m12tfn

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WANTED: ONE OR TWO general practitioners and surgeons, singly or a team, to fill void left by death of two physicians. Twenty-seven bed hospital well equipped located in village surrounded by large rural area. No other physicians in community. Contact J. H. Twetan, Iola, Wisconsin. 6tfn

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WANTED: GENERAL PRACTITIONER to become associated with small group in central Wisconsin, preferably one who has had some practical experience, and has a special interest in obstetrics; also willing to only assist in surgery. Contact Dept. 969 in care of the Journal. m2tfn

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WANTED: GENERAL PRACTITIONER as a replacement in town of 1,275 in southern Wisconsin. Gross receipts $42,000 in 1961, over $24,000 first 6 months 1962. Unopposed, good schools, churches, roads, fishing. Nearby accredited 200 bed hospital. Leaving for residency. Contact: D. L. Minter, M.D., Clinton, Wis. m9tfn

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WANTED: GENERAL PRACTITIONER to replace physician who left for residency training. Fully equipped office available immediately. Town of 2,100 offers good hospital, skiing, hunting, golf, fishing and many other recreational advantages along the Chippewa River near its junction with the Mississippi. Financial remuneration should be excellent from the start. Contact Dept. 7 in care of the Journal. m9tfn

---

WANTED: GENERAL PRACTITIONER for associate with two other general practitioners in community of 2,400 with trade area of 7,000 in Green county. No investment required. Excellent clinical and diagnostic facilities. 200 bed hospital 15 miles. Good educational facilities. Convenient communications to recreational areas. Contact M. W. Stuessy, M.D., Brodhead. m3tfn

---

WANTED: YOUNG GENERAL SURGEON for associate leading to partnership in one year if mutually agreeable. Mldeastern Wisconsin. Contact Dept. 9 in care of the Journal. m9tfn

GOOD LOCATION AVAILABLE for general practitioner. Nothing to buy. Will assist and refer all general practice cases. Contact C. A. Sholtes, M.D., Richland Center, Wis., Midway 7–2592 or 7–2544. m9tfn

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ITEMS FOR SALE: 1 model E CDX General Electric dental x-ray unit, 15 years old; 1 model KX-10 General Electric stationary x-ray unit (superficial x-ray therapy), 7 years old; 1 General Electric fluoroline truvision stereoscope mounted on adjustable floor stand, 15 years old. Items in excellent condition, can be purchased for reasonable price. Write: Mr. V. L. Meyer, Business Manager, The Sheboygan Clinic, Sheboygan, Wisconsin. 3

WANTED: GENERAL PRACTITIONER to take over practice or partnership in excellent rural community. Open staff hospital. Should net $20,000 first year. Send inquiries to Dept. 17 In care of the Journal. m10–3

FOR SALE: RADIOLOGIST has for sale radiographic and therapy equipment, seven-room office occupied over 40 years in professional building main corner city of 35,000. Southern Wisconsin. Reasonable price. Contact Dept. 988 in care of the Journal. m6tfn

---

FOR SALE: GENERAL PRACTICE, well trained and active, in new fully equipped clinic building. Present physician leaving for residency. Personnel well trained and efficient. Rural village 38 miles northeast of Madison. New school, swimming pool, good housing available. Subsidy can be arranged through village. Contact Joseph G. Brown, M. D., Cambria, Wisconsin. m6tfn

---

FOR SALE: GENERAL PRACTICE in Chippewa Falls, Wis.; well established, same location for 17 years, fully equipped 5½-room office. Will take any reasonable offer and finance as you wish. Office help available. Practice available because of recent death of William F. Janc, M.D. Contact Mrs. William F. Janc, 300 Macomber Street, Chippewa Falls, Wis. m7tfn

---

PHYSICIANS, with or without pediatric training, needed in maternal and child health program at salaries ranging from $9,960.00 to $13,200.00. Five-day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, Milwaukee Health Department, Municipal Building, Milwaukee 2, Wis. g8tfn

---

WANTED: GENERAL PRACTITIONER as associate in a four-man group with adequate clinical facilities. Offer open for two or three year locum tenens or for permanent association in the group. Town of 4,000, well-equipped 80-bed hospital, in west central Wisconsin. Contact Dept. 10 in care of the Journal. m9tfn

---

EENT SPECIALIST NEEDED for Eau Claire and vicinity, population 60,000. Could take over 20-year practice of deceased physician. Very advantageous opportunity. Contact Mrs. S. B. Russell, 114½ Grand Avenue West, Eau Claire, Wis. m3tfn

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WANTED: USED EQUIPMENT of a physician. Young physician establishing private practice in Madison interested. Contact Dept. 34 in care of the Journal. m3tfn

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WANTED: LOCUM TENENS for the month of May. Will pay $1,000 for the month, but person must find own living quarters. Physician who seeks locum tenens will be available part of the time during the month. Contact Dept. 35 in care of the Journal. m3–4

FOR SALE: INDEPENDENT PRACTICE in internal medicine in Marshfield, Wis., population 15,000, medical center for area of 50-mile radius and 75,000 population. Hospital of 268 beds with 105-bed addition nearly completed. Established in 1956, practice has grossed $75,000 per year for past three years. Excellent records, eight-room suite of offices, laboratory equipment available. Financial arrangements flexible. Contact Mr. Ralph Crain, 800 S. Drake Ave., Marshfield, Wis., phone area code 715, FUlton 4–2915, or C. Bruce Taylor, M.D., Department of Pathology, Evanston Hospital, Evanston, Ill., phone area code 312, UNiversity 9–2500, Ext. 760. m12tfn

ALLERGIST WANTED to share offices with dermatologist. Located in thriving area, south central Wisconsin. Unusual opportunity. Applicant must be board certified or qualified and intending to become certified. Reply, with details of personal and professional qualities and qualifications, to Dept. 5 in care of the Journal. m8tfn

WANTED TO RELOCATE: Solo general practitioner in same office over 20 years must yield present location. Prefer to locate in rural area where a GP needs assistance or wishes to retire. Will consider serving in any way compatible and fitting within the sphere of mutual concern. Any inquiries will be held confidential with no expense or obligation. Contact Dept. 18 in care of the Journal. m11tfn

WANTED: INTERNIST for newly formed professional corporation in northeastern Wisconsin. Ideal living conditions and superior opportunity for advancement. Salary during first two years of association. Contact Dept. 25 in care of the Journal. 1tfn

POSITION WANTED: Anesthesiologist, young, married, personable, Wisconsin-trained physician, now completing anesthesia residency, desires location and association in a progressive community requiring specialty practice July 1963. Contact Dept. 27 in care of the Journal. m1tfn

OUTSTANDING OPPORTUNITY for a young physician who is willing to work. Good schools, good 100-bed hospital. Good fishing and hunting. Retiring. Contact Dept. 32 in care of the Journal. m2–3

ORTHOPAEDIC SURGEON, Board certified, military obligation completed, married, family, prefers smaller communitty, orthopaedic associate, small group or solo practice. Contact Dept. 40 in care of the Journal. p3

WANTED: Certified or qualified specialist in—

1. Plastic Surgeon	6. Orthodontist
2. ENT	7. Neurology
3. Ophthalmology	8. Pathology
4. Psychiatry	9. Anesthesiology
5. Proctology	10. Neurosurgeon

to join 27-man, all-specialist group. Contact Robert G. Zach, M.D., The Monroe Clinic, Monroe, Wis. 3tfn

FOR RENT: OFFICE SPACE, 1200 sq. ft., for medical offices in modern, air-conditioned building at 16 East Gorham Street, Madison. Available for immediate occupancy. Will accommodate one or two physicians, preferably internists. Off-street parking. Contact Robin Allin, M.D., 1313 Fish Hatchery Road, Madison, Wis., phone ALpine 6–5521; or residence CEdar 3–2082. m8tfn

HELP! Two-man practice with only one man! General practitioner. Small town. Salary first year; partnership later. T. S. Westcott, M.D., 115 West Chestnut St., Pardeeville, Wis. m3tfn

GENERAL PRACTITIONER desires associate or partner. Liberal terms. No down payment. Two open staff hospitals. Plenty of work and plenty of recreational opportunities. A. B. Kores, M.D., Beaver Dam, Wis. m3tfn

WANTED: GENERAL PRACTITIONER or man with specialty who will do general practice and associate with one or two other men in well established practice. Fox River Valley. Immediate opening. Community of 50,000. Salary two years, then partnership. Contact Dept. 38 in care of the Journal. m3

WANTED: METAL HAMILTON TABLE, recent model, in good condition. Contact Dept. 30 in care of the Journal. m1tfn

OFFICE SPACE in medical clinic, 2218 North Third Street, Milwaukee, Wis.; Co. 4–2800. m3tfn

WANTED: GENERAL PRACTITIONER to join general practitioner in well established practice in southeastern Wisconsin. Town of 8,000. Class A accredited hospital. Salary or partnership if mutually agreeable. Contact Dept. 39 in care of the Journal. m3–5

WANTED: GENERAL PRACTITIONER with interest in surgery and obstetrics for physician now grossing over $50,000 and planning retirement within five years. To take over entire practice ultimately and now enter into partnership agreement until final termination of practice occurs. Excellent opportunity, no investment involved, full hospital privileges to qualified person. Large southeastern Wisconsin industrial city. Contact Dept. 13 in care of the Journal. m11tfn

WANTED: GENERAL PRACTITIONER to replace retired physician in established three-man group. Must be interested in general medicine, obstetrics, and willing to assist in surgery. Fully equipped medical suite including x-ray and laboratory in town of 50,000 in Fox River Valley of Wisconsin. Unusual opportunity with eventual partnership. Contact Dept. 36 in care of the Journal. m3tfn

WANTED: GENERAL PRACTITIONER to join physician in a large medical and surgical practice. Newly constructed clinic and 30-bed hospital. Beginning salary: $15,000 annually plus percentage. Good agricultural and industrial small town in the heart of Wisconsin. Finest recreational areas yet extremely close to the twin cities, Minneapolis and St. Paul. Contact Dept. 37 in care of the Journal. m3tfn

PHYSICIAN WANTED: General practitioner in northeastern Wisconsin wants part time help. Can use one man or combination to cover practice for week, month, or up to a year. Money no object for right man. No OB or surgery unless desired. Living facilities and car available. Contact Dept. 29 in care of the Journal. m1tfn

FOR SALE: Genophthalmic chair, Genophthalmic refractor, Claison projector, eye glass display cabinet, treatment table, records from eye, ear, nose and throat practice—42 years. Price very reasonable. J. J. Sharpe, M.D., 150 E. First St., Fond du Lac; telephone 291 and 349. m3tfn

WANTED: PHYSICIAN for Wisconsin State Prison at Waupun, Wis. Eight-hour day, five-day week, retirement, civil service benefits. No office to maintain, no bills to collect, no obstetric cases. Beginning salary $10,596 to $14,196 depending upon qualifications. Salary can go to $17,796 per year. Write John C. Burke, Warden, Wisconsin State Prison, Waupun, Wis. 1–3

WANTED: PHYSICIAN to associate with two established general practitioners in southeastern Wisconsin industrial, agricultural community of 6,000. Prefer one who has had special surgical training and willing to do general practice along with surgery. Contact Dept. 31 in care of the Journal. m1–3

WANTED: Young, ambitious general practitioner needed at once at the Janesville Medical Center, 2020 E. Milwaukee St., Janesville, Wis. Salary for first year; and if mutually agreeable after one year, may become partner. Contact Duane F. Alexander, Business Manager. 3tfn

INTERNIST WANTED: Fourteen-man Iowa group has opening for Board qualified internist. City of 30,000, new clinic building, complete laboratory and x-ray. Partnership in two years; salary open. Contact Dept. 26 in care of the Journal. 1–3

COMMERCIAL

HOME ELEVATOR FOR SALE: A stairway chair-type home elevator in excellent condition. Two years old. Contact Estate Executor, Frank A. Murphy, Commerce Building, Manitowoc, Wis. Telephone 684–4479. 3

WANTED: Advertisements for this new section. Open for physicians, individuals, firms, organizations who have something they would like to sell, or are looking for something to buy, or have a service available, which might be of interest to physicians.

INDEX TO ADVERTISERS

	Page
Abbott Laboratories	19, 20
American Tobacco Company	22
Ames Company	59
Barr X-ray Co.	32
Borden's	16
Bristol Laboratories	12, 13
Burroughs Wellcome & Co., Inc.	6, 40, 41
Chatham Pharmaceuticals, Inc.	27
Ciba Pharmaceuticals	43
Coach House Motor Inn	33
Davies, Rose & Company, Ltd.	54
Endo Laboratories	21
Haug Drug Company	34
Hotel Schroeder	32
House of Bidwell, Inc.	32
Hurley X-ray Company	16
Keeley Institute	32
Lederle Laboratories	8, 9, 49
Lilly and Company, Eli	Front cover, 30
Medical Protective Company	4
Mid-Western Sport Togs	37
Milwaukee Sanitarium Foundation	16
Northwest Psychiatric Clinic	44
Parke, Davis & Company	2, 3
Pfizer Laboratories	24, 25
Phillips Co., The Chas. H., Division of Sterling Drug Co., Inc.	17
Physicians Exchange	55, 56, 57
Physicians Mutual Insurance Co.	32
Poythress & Co., Inc. Wm. P.	7, 48
Rennebohm's	16
Robins Co., Inc., A. H.	28
Roche Laboratories	Back cover
Roerig & Co., J. B.	50, 51
Rogers Memorial Hospital	46
Sacred Heart Sanitarium	10
St. Croixdale Sanitarium	4
Sardeau, Inc.	26
Schering Corporation	29
Searle & Co., G. D.	31
Shorewood Sanitarium	37
Smith Kline & French Laboratories	14
Squibb & Sons, E. R.	47
Time Insurance Co.	37
Tutag & Co., S. J.	46
Wallace Laboratories	15, 23, 42
Winthrop Laboratories	11, 18
Wisconsin Physicians Service	52, 53

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CONTENTS

Vol. 62, No. 4 APRIL 1963

SCIENTIFIC ARTICLES

Autopsy Incidence of Otitis Media in Infants, by Dale E. Van Warmer, M.D., Madison -- 183

Fetal Distress in Labor, by Jack A. Kleiger, M.D. and John R. Evrard, M.D., Milwaukee 185

Spontaneous Rupture of the Esophagus, by Thomas E. Lynn, M.D., Green Bay ------ 191

Clinicopathologic Conference, by H. J. Dick, M.D., Sheboygan ---------- 195

SPECIAL FEATURES

Hospital Employee Health Service, by James L. Wardlaw, M.D., and Catherine Chambers, R.N., Madison ---------- 190

The Satisfactions of Being a General Practitioner ---------- 194

What are Laboratory Tests Costing Your Patient? ---------- 194

Four Approved Medical Assistant Courses in State by September ---------- 201

Shortage of Gamma Globulin ---------- 201

Comments on Treatment: Sparteine—A New Oxytocic Drug, by Albert C. Yard, M.D., Ph.D., Milwaukee ---------- 202

Trichlorethylene, Trilene®, Trimar® Analgesia in Obstetrics ---------- 203

Comments from the Press: Chief Argument for Aged Care Isn't True ---------- 206

1963 SMS Annual Meeting Highlights ---- 41

Activities at SMS Headquarters ---------- 62

Official Notice: Amendments to the Constitution Introduced at 1962 Session of House of Delegates and to be Acted Upon by 1963 House of Delegates in May ------ 70

EDITORIALS

President's Page: The Value of Quality, by N. A. Hill, M.D., Madison ---------- 204

Serious Shortage ---------- 205

REGULAR FEATURES

Letters of Interest ---------- 7

County Society Proceedings ---------- 55

Specialty Society Proceedings ---------- 57

News of Wisconsin Physicians ---------- 59

Obituaries ---------- 65

Facts about Wisconsin Physicians Service -- 68

Medical Meetings—Postgraduate Courses -- 69

Calendar of Meetings ---------- 69

Physicians' Exchange ---------- 71

List of State and County Officers and Scheduled Meetings of County Medical Societies 74

Index to Advertisers ---------- 76

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ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 303 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

Journal
Established 1903

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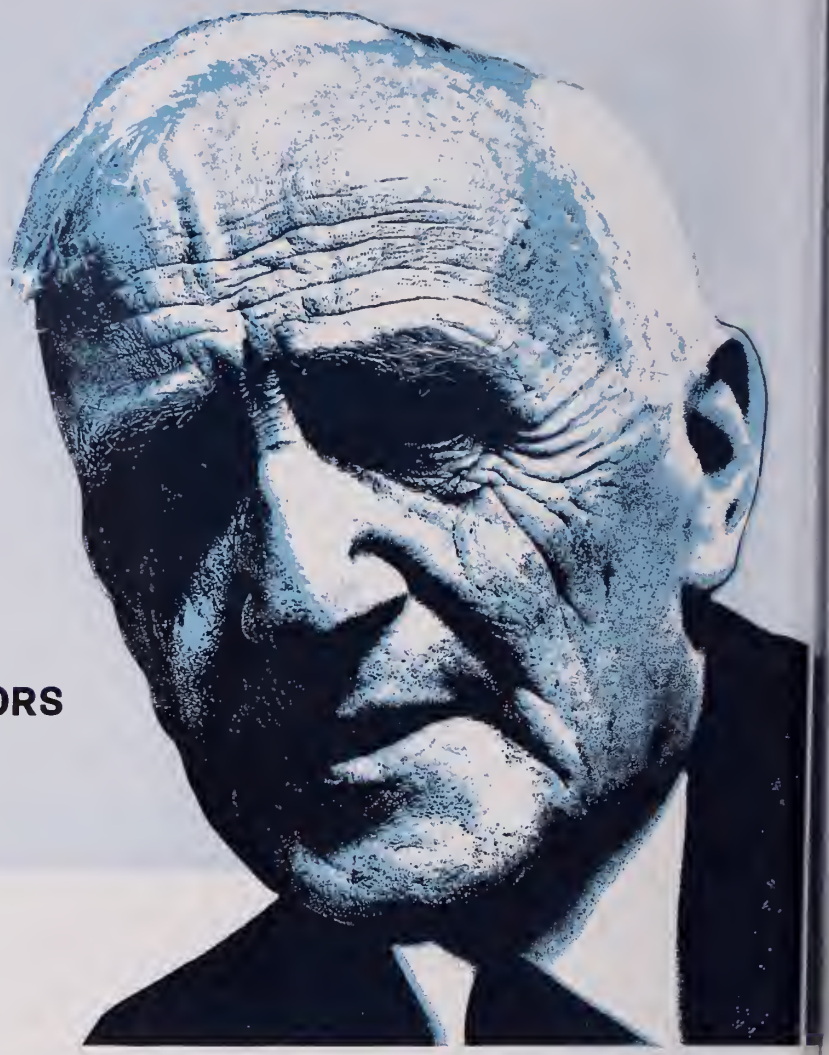
For your elderly arthritic patients



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1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

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FALLOUT SURVEILLANCE

Letters of Interest

TO THE EDITOR:

I would appreciate the opportunity to discuss "Fallout Surveillance," by William L. Lea, Ph.D., which appeared in the December 1962 issue (*Wisconsin Medical Journal*). Undoubtedly Doctor Lea's intention was to elucidate this problem which is, or should be, a great source of concern to all of us. Unfortunately, the effect of his article was to minimize the problem and to tend to lull us into a false sense of security. His message seemed to me to be: Big brother is looking out for you, so just forget all about it.

In Public Affairs Pamphlet No. 256, Dr. James F. Crow, professor of genetics at the University of Wisconsin, who was a member of the Committee on the Genetic Effects of Radiation of the National Academy of Sciences, National Research Council, writes on the topic "Effects of Radiation and Fallout." Doctor Crow agrees the present rate of fallout in the U. S. as determined by "Project Sunshine" of the AEC is less than 5% of what we receive as natural radiation.

Doctor Crow then explains the effects of radiation on mutations and states: "The number of mutations is strictly proportional to the total amount of radiation reaching the reproductive cells. It makes no difference whether a person receives one roentgen per year for ten years or ten roentgens all at once. the genetic effect is the same. Geneticists are convinced that there is no threshold, i.e., no dose too low to produce any mutations. Thus there is no such thing as an entirely harmless or 'safe' dose."

Doctor Crow goes on to say that mutational damage is spread over 30–50 generations, which means 1000–2000 years. He states, "The number of persons exposed to fallout is as large as the world population, and this means that spread over the whole world in space, and centuries in time, will be tens of thousands or more persons who will be diseased, or deformed, or will die prematurely or be otherwise impaired as a result of tests already done. The fraction is tiny, but the numbers are enormous."

Somatic effects of fallout are also discussed by Doctor Crow and again he concludes, based on the evidence available, that a number of cases of leukemia and cancer are being induced, which considering the world population, comprise a large absolute number.

Dr. Herman J. Muller, Nobel prize-winning geneticist, is concerned about the impairment of the apparently normal and he fears that this will be a much greater burden on the human race than the increased number of obvious defectives. He warns, "Our genetic heritage is the most precious thing we have. If it deteriorates, we deteriorate. The human race must become genetic conscious."

"Maximum permissible concentration" is a term coined by the AEC to suggest how much strontium 90, I-131, etc. can be tolerated. These figures, as established officials are tripping all over themselves to tablished, are not scientifically valid and have already been changed several times.

"Permissible concentration" is considered by some scientists to be a way of rationing poor health so that it won't become evident too soon. Dr. Albert Schweitzer asks, "Who permits it? Why is it permitted?"

Prepared Summary of Testimony by Irving Michelson, Consumers Union, presented to the Joint Committee on Atomic Energy on June 5, 1962, stated "The fallout monitoring systems have serious deficiencies with respect to speed and effectiveness; information is not available soon enough to take any preventive action which may be warranted. The total diet samples (especially useful for medium and long-lived radioisotopes such as strontium 89, strontium 90, and cesium 137) do not give us data until three or four months after the food has been eaten.

"The network requires about two months for reporting such data. But this network also is capable of reporting the short-lived iodine-131 within a few days, and is especially valuable for this reason. The air network, which should act as an early warning system to warn us of approaching radioactive contamination, is of very limited value, if not misleading. The air network failed to give warning of high iodine-131 levels in milk in most places in the U. S. last fall."

Representative John V. Lindsay (R–N.Y.) spoke before the U. S. House of Representatives on June 18, 1962. His words are worth repeating:

"Mr. Speaker, in last Friday's *New York Times*, there appeared an article by John Finney on the subject of the continued high level iodine-131 content in milk in certain areas of the Midwest. Though the subhead read: 'U. S. Discounts Peril', the vagueness of the article made it extremely alarming.

"In order to obtain more concrete information on the fallout situation, I had a member of my staff contact the Public Health Service to ascertain the facts and figures behind Mr. Finney's story. The results were astounding. The Public Health Service seemed no better briefed on the potential danger of iodine-131 than Mr. Finney had been. Their every statement was couched in reservations.

"The average iodine-131 content of milk is in the vicinity of 20 micromicrocuries per liter, they said. But as of May 24, (1962) the level of iodine-131 in some areas had exceeded 600 micromicrocuries per liter. What is the significance of these figures? Nobody seems quite sure. The Federal Radiation Council has established a guideline of 36,500 mmc's as the amount of iodine-131 which a person can safely absorb each year without any fear of thyroid damage. This figure breaks down to 100 mmc's per day. But, now that radiation levels are rising, public

assure us that this guideline was established for industrial exposure. It was not meant to apply to fallout.

"As far as the American public knows, we are still faced with what Mr. Finney called 'the unresolved question of when counter-measures would be ordered against milk contaminated by fallout.' Just try and find someone who will tell you how much fallout is dangerous. You can't do it. If anybody knows, he isn't telling. Two weeks ago the Subcommittee on Research Development and Radiation of the Joint Committee on Atomic Energy conducted hearings on radiation standards, including fallout. But a long roster of distinguished experts was unable to provide assistance in answering the specific questions which are giving rise to such anxiety all over the country. Mothers are afraid for their children. Men fear for their families. They all want to know—they have a right to know the facts. How much iodine-131 is too much? How can we calmly proceed with atmospheric nuclear tests when we seem to have such a hazy idea of where we are going, of what we are doing? Where public health is concerned, there is no room for unresolved questions. When we are dealing with human lives, we cannot tolerate generalities and evasiveness.

"At the Atomic Energy Subcommittee hearings, Dr. Russell H. Morgan, chairman of the Public Health Service's National Advisory Committee on Radiation, said if the Soviet Union resumed testing shortly, the radiation dose to the thyroid would probably exceed radiation protection guides in several cities and this would 'immediately raise very serious problems of counter-measures.' Doctor Morgan emphasized the importance of carefully defining the responsibility for counter-measure application. But I want to know more than just who is responsible for such action. I also want to know exactly what measures are proposed and under what circumstances they will be taken.

"The Joint Committee on Atomic Energy owes it to every member of Congress to conduct a thorough investigation of the fallout problem and to publish their findings as soon as possible. But of even more crucial importance at this juncture is the duty of the President to provide the American people with a complete statement of the facts, and I call upon him to do so. If the facts are not available, then the President owes it to the people to step up research in this critical area until all statistics are rendered meaningful, all ambiguities are clarified, and all doubts are erased."

As physicians our primary concern is for the welfare of human beings without regard for race, creed, color, or ideology. We have a responsibility to humanity to stand in opposition to the destructive forces rampant in the world today.

CARL L. KLINE, M. D.
Wausau

W.S.M.A. ADVISOR INFORMED

To DOCTOR REZNICHEK:

We are again beginning our meetings of the council which are held during each school year. The first is to be held this coming Thursday evening, September 27. We will try to have the same type of arrangement for our meetings as we did last year, with a meeting time of about 5:45 or 6:00 P. M. and in the same room as last year. Again we intend to have at least one meeting each month. I will try to inform you of each meeting at least a week in advance.

May I express the thanks of our organization to you for your valued counsel and advice in past years. We again look forward to having your presence with us in our activities and hope that you will again provide us with guidance as we conduct our affairs.

It is especially valuable to an organization as ours, which changes membership every four years, to have the help of an organization such as the State Medical Society and yourself as their well qualified representative.

Thank you in advance for your assistance.

ROBERT D. HEINEN
Wisconsin Student Medical Association

(EDITOR'S NOTE: Dr. C. G. Reznichek, Madison, is the State Medical Society's advisor to the WSMA.)

LIKES PRESCRIPTION DRUG COVERAGE

To SMS:

Wisconsin Physicians Service and medicine can be congratulated on the inclusion of prescription drugs in the health insurance coverage plans being offered to the buying public.

This is a very forward and much needed step, another event in the panorama of what can be done by private medicine and insurance groups working toward better medical care at a price people can afford.

JOHN ALLEN, M. D.
Consultant—Medicine
State Department of Public Welfare

THANK YOU

To SMS:

As Chairman of the Committee on Program of the Wisconsin Nurses Association Office Nurses Section, I wish to thank you for the publicity given the office nurses in your magazine.

From the many fine comments we heard from our members, we feel our program was quite a success.

Thank you, again, for the consideration you gave us in publicizing it.

FLORENCE KOBUS, R.N.
Chairman
Committee on Program
WNA Office Nurses Section

Honoring the 50th Anniversary of Marquette University School of Medicine, Milwaukee

STATE
MEDICAL
SOCIETY
OF
WISCONSIN

ANNUAL MEETING

MAY 6·7·8·9
1963

MILWAUKEE AUDITORIUM
HOTEL SCHROEDER

Milwaukee

R. W. FARNSWORTH, M.D.
Chairman, Commission on Scientific Medicine (left)

P. T. BLAND, M.D.
Chairman, Round Table Luncheons (lower left)

A. R. CURRERI, M.D.
Chairman, General Program (lower right)

Each year brings new discoveries and varying modes of therapy of concern to every alert physician. With this in mind, the Commission on Scientific Medicine has arranged a varied and interesting program for the 1963 Annual Meeting. Participation in this meeting by way of attendance is an important part of a physician's progress in medical knowledge.

1963 ANNUAL MEETING
TIMETABLE

MONDAY, MAY 6

6:00 p.m.—Buffet supper for Delegates and Officers, at Hotel Schroeder
6:30 p.m.—Registration of House of Delegates, at Hotel Schroeder
7:00 p.m.—First session, House of Delegates, at Hotel Schroeder

TUESDAY, MAY 7

8:00 a.m.—Registration at Auditorium
Exhibits open at Auditorium
9:00 a.m.—Reference Committees, House of Delegates, at Hotel Schroeder
9:00 a.m.—Medical Care of the Aged conference, at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Marq. U. and U. of W. medical schools' alumni luncheons at Auditorium
2:00 p.m.—Medical Care of the Aged conference continued, at Auditorium
7:30 p.m.—Second session, House of Delegates, at Hotel Schroeder
8:00 p.m.—Fireside Conferences, at Hotel Schroeder

WEDNESDAY, MAY 8

8:00 a.m.—Registration at Auditorium
9:00 a.m.—Exhibits open at Auditorium
9:00 a.m.—Third Session, House of Delegates, at Hotel Schroeder
9:00 a.m.—General Scientific Program, at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Luncheon for officers and trustees of SMS Charitable, Educational and Scientific Foundation, at Hotel Schroeder
12:15 p.m.—Luncheon for Wisconsin Clinic Managers Association, at Milwaukee Athletic Club
2:15 p.m.—Special Interest Programs on obstetrics and gynecology, pathology, psychiatry, and radiology, at Auditorium
6:30 p.m.—President's reception, at Hotel Schoeder
7:15 p.m.—Annual dinner, at Hotel Schroeder

THURSDAY, MAY 9

8:00 a.m.—Registration at Auditorium
9:00 a.m.—Exhibits open at Auditorium
9:00 a.m.—Medical Aspects of Sports conference, at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Past President's luncheon, at Hotel Schroeder
2:00 p.m.—Special Interest Programs on anesthesiology (at Auditorium), ophthalmology and otolaryngology (at Hotel Schroeder), pediatrics (at Auditorium), and surgery (at Auditorium)

Out-of-State Guest Lecturers

ROBERT W. BAILEY, M. D.
Associate Professor of Surgery, University of Michigan Medical School; Administrative Head, Section of Orthopaedic Surgery, Department of Surgery, University of Michigan Medical Center, Ann Arbor, Mich. (Marquette graduate 1946)

IVAN D. BARONOFSKY, M. D.
Clinical Professor of Surgery, University of Southern California School of Medicine (Los Angeles), San Diego, Calif. (Marquette graduate 1943)

LAWRENCE R. BOIES, M. D.
Professor and Chairman, Department of Otolaryngology, University of Minnesota Medical School, Minneapolis, Minn.

JOHN J. BONICA, M. D.
Professor and Chairman, Department of Anesthesiology, University of Washington School of Medicine, Seattle, Wash. (Marquette graduate 1942)

WILLIAM E. CONNOR, M. D.
Department of Internal Medicine, State University of Iowa, Iowa City, Ia.

LAWRENCE A. DAVIS, M. D.
Professor of Radiology, University of Louisville School of Medicine, Louisville, Ky.

R. H. FERGUSON, M. D.
Clinical Section, Mayo Clinic, Rochester, Minn.

EMIL FREI, III, M. D.
Chief, Medical Branch, National Cancer Institute, U. S. Public Health Service, Bethesda, Md.

J. E. GERACI, M. D.
Clinical Section, Mayo Clinic, Rochester, Minn. (Marquette graduate 1942)

FRANK J. GLASSY, M. D.
Clinical Pathologist, Sacramento Clinical Laboratories and Sutter Community Hospitals, Sacramento, Calif. (Marquette graduate 1946)

EDWARD CUYLER HAMMOND, Sc. D.
Director, Statistical Research Section, Medical Affairs Department, American Cancer Society, New York, N. Y.

GEORGE J. HAMWI, M. D.
Professor of Medicine and Director, Division of Endocrinology and Metabolism, Ohio State University, Columbus, O.

ELIHU S. HOWLAND, M. D.
Chicago, Ill.

ORMAND C. JULIAN, M. D.
Professor of Surgery, University of Illinois College of Medicine, Chicago, Ill.

PETER C. KRONFELD, M. D.
Professor and Chairman, Department of Ophthalmology, Illinois Eye and Ear Infirmary, University of Illinois College of Medicine, Chicago, Ill.

ELLIOT O. LIPCHIK, M.D.
Department of Radiology, Strong Memorial Hospital, Rochester, N. Y.

C. G. MENDELSON, M. D.
Henry Ford Hospital, Department of Dermatology, Detroit, Mich.

CLYDE L. RANDALL, M. D.
Chairman, Department of Obstetrics and Gynecology, State University of New York at Buffalo, Buffalo, N. Y.

JOHN ROMANO, M. D.
Professor of Psychiatry, Psychiatrist-in-Chief, University of Rochester School of Medicine and Dentistry and Strong Memorial Hospital, Rochester, N. Y. (Marquette graduate 1934)

ROBERT M. SMITH, M. D.
Director of Anesthesia, Children's Hospital Medical Center, and Clinical Professor of Anesthesiology, Harvard Medical School, Boston, Mass.

JEREMIAH STAMLER, M. D.
Director, Chronic Disease Control Division, City of Chicago Board of Health, Chicago, Ill.

FREDRICK J. STARE, M. D.
Department of Nutrition, Harvard University School of Public Health, Boston, Mass.

HERBERT A. WENNER, M. D.
Associate Professor of Pediatrics and Bacteriology, Department of Pediatrics, Section of Virus Research, University of Kansas Medical Center, Kansas City, Kan.

GRANGER E. WESTBERG, D. D.
Associate Professor of Religion and Health, Medical and Theological Faculties, University of Chicago, Chicago, Ill.

ANNUAL DINNER

Wednesday Evening
May 8

GUEST SPEAKER

Edward R. Annis
M. D.
President-Elect
American Medical
Association

- President's Reception, 6:30
- Annual Dinner, 7:15
- Presentation of Fifty-Year Club Awards
- Selections by the Marquette University School of Medicine Glee Club
- Dancing to the music of The Executives

MAIL YOUR ADVANCE REGISTRATION TODAY

See Page 51

Honoring
THE FIFTIETH ANNIVERSARY
Marquette University School of Medicine

In 1913, the Milwaukee Medical College and Wisconsin College of Physicians joined with Marquette University to form a new medical school. Since that date the Marquette University School of Medicine has been a major factor in establishing the high level of medical care enjoyed today by Wisconsin residents.

A half-century of service to Wisconsin, education of a generation of physicians, countless contributions to the field of medicine—for these and other accomplishments the State Medical Sociey of Wisconsin, at its 122nd annual meeting, honors the Fiftieth Anniversary of the Marquette University School of Medicine.

ANNUAL DINNER

Wed., May 8

MAIN SPEAKER
A Marquette Alumnus

Edward R. Annis, M. D.

President-Elect
American Medical Association

Who Are Alumni of Marquette University School of Medicine

ROBERT W. BAILEY, M. D.
(Class of 1946), Department of Orthopedic Surgery, University of Michigan Medical School, Ann Arbor, Mich.

IVAN D. BARONOFSKY, M. D.
(Class of 1943), Clinical Professor of Surgery, University of Southern California School of Medicine, San Diego, Calif.

JOHN J. BONICA, M. D.
(Class of 1942), Professor and Chairman, Department of Anesthesiology, University of Washington School of Medicine, Seattle, Wash.

J. E. GERACI, M. D.
(Class of 1942), Clinical Section, Mayo Clinic, Rochester, Minn.

FRANK J. GLASSY, M. D.
(Class of 1946), Dept. of Pathology, Sutter Community Hospitals, Sacramento, Calif.

JOHN ROMANO, M. D.
(Class of 1934), Professor of Psychiatry and Psychiatrist-In-Chief, Strong Memorial Hospital, University of Rochester School of Medicine, Rochester, N. Y.

PROGRAM HIGHLIGHTS

TUESDAY, MAY 7

Medical Care of the Aged

PLANKINTON HALL, MILWAUKEE AUDITORIUM

A special conference sponsored by the State Medical Society's Division on Aging of the Commission on State Departments, in cooperation with the Wisconsin Society of Internal Medicine and the Wisconsin Academy of General Practice.

Moderator for the conference will be Adolph M. Hutter, M.D., Fond du Lac, Chairman of the Division on Aging. Out-of-state guest lecturers include: Drs. O. C. Julian, Chicago; George Hamwi, Columbus; E. C. Hammond, Sc.D., New York City; F. J. Stare, Boston; Jeremiah Stamler, Chicago; W. E. Connor, Iowa City; R. H. Ferguson, Rochester; E. S. Howland, Chicago; and G. E. Westberg, D.D., Chicago.

The conference will start at 9 a.m. and adjourn at 5 p.m.

Fireside Conferences

EAST ROOM, HOTEL SCHROEDER FIFTH FLOOR

These conferences are sponsored by the Wisconsin Chapter of the American College of Chest Physicians. Dinner will be served at 6:30 p.m. followed by the conference at 8 p.m.

Eleven subjects will be discussed simultaneously at eleven tables. Physicians are welcome to table hop, listen or participate in the informal discussions. Refreshments will be served. Subjects and the leaders of the discussions appeared in the February and March issues of the WMJ.

Subjects to be covered include Coronary Disease, Cardiac Surgery, Electrocardiograms, Acute Rheumatic Fever, Clinical Cardiology, Chronic Lung Disease, Bronchial Asthma, Chest X-Rays, Pulmonary Function Studies, Pulmonary Tuberculosis and Fungus Diseases, and Lung Cancer.

Leaders of the discussions will be Drs. Howard Correll, Julius Meyer, Herman Shapiro, Vincent Gott, Derward Lepley, Jr., William Young, Armin Baier, D. J. Nuyda, Francis Rosenbaum, Richard Wasserburger, William J. Gallen, Gerson Bernhardt, John Huston, George Hellmuth, Mischa Lustok, Leon Hirsh, Ross Kory, Avrum Organick, John Rankin, John Arkins, Abe Sosman, John Talbot, John Amberg, Donald Babbitt, Jerome Marks, J. Bernard Gee, David Rosenzweig, Walter Thiede, Helen Dickie, William Stead, Fred J. Ansfield, Anthony Curreri, John R. Pellett, and Albert Pemberton.

House of Delegates Activities

Meetings of the House of Delegates are regarded as among the most important functions of the Annual Meeting of the State Medical Society. Reports of the officers and committees, as well as new business, will be presented at the initial session of the House at 7:00 p.m., Monday, May 6.

ALL MEETINGS OF THE HOUSE AND REFERENCE COMMITTEES WILL BE HELD AT HOTEL SCHROEDER

MONDAY, MAY 6

P.M.

6:00—BUFFET SUPPER for Delegates and Officers
Hotel Schroeder, Pere Marquette Room (fifth floor)

6:30—REGISTRATION OF THE HOUSE OF DELEGATES
Hotel Schroeder (fifth floor foyer)

7:00—FIRST SESSION: HOUSE OF DELEGATES
Hotel Schroeder, Ball Room (fifth floor)

TUESDAY, MAY 7

A.M.

9:00—REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES

COMMITTEE ON NOMINATIONS:
Hotel Schroeder, Pine Room (fifth floor)

COMMITTEE ON RESOLUTIONS:
Hotel Schroeder, Ballroom (fifth floor)

COMMITTEE ON REPORTS OF OFFICERS:
Hotel Schroeder, Room 507 (fifth floor)

COMMITTEE ON REPORTS OF STANDING COMMITTEES:
Hotel Schroeder, Room 508 (fifth floor)

All those concerned with work of these committees, who wish to express their views on reports or resolutions to be acted upon at the second session of the House, on Tuesday evening, are asked to please appear before the appropriate Reference Committee **before noon on Tuesday,** so proper reports can be prepared on Tuesday afternoon.

P.M.

7:30—SECOND SESSION: HOUSE OF DELEGATES
Hotel Schroeder, Ballroom (fifth floor)

WEDNESDAY, MAY 8

A.M.

9:00—THIRD SESSION: HOUSE OF DELEGATES
Hotel Schroeder, Ballroom (fifth floor)

Special Dinners or Social Functions

(For members of specialty groups only)

WEDNESDAY, MAY 8

6:00 p.m.—WISCONSIN SOCIETY OF PATHOLOGISTS dinner at Mamie's Grotto, 624 East Detroit St. Reservations: Edwin L. Bemis, M.D., Wisconsin Society of Pathologists, 561 N. 15th St., Milwaukee. **No money with reservation,** but please contact Doctor Bemis if you plan to attend, so proper arrangements can be made. **Wives are not to be included.**

7:00 p.m.—WISCONSIN RADIOLOGICAL SOCIETY dinner meeting, University Club. Social hour starts at 6:15 p.m. Chairman: Eugene Sengpiel, M.D., Milwaukee. Speaker: L. A. Davis, M.D., Louisville, Ky.—"Surgical Emergencies of the Newborn." Dinner limited to members, physician guests, and radiology residents. Reservations to Robert Byrne, M.D., Columbia Hospital, Milwaukee.

THURSDAY, MAY 9

5:30 p.m.—WISCONSIN SECTION OF THE AMERICAN ACADEMY OF PEDIATRICS dinner at the Coach House Motor Inn, 19th and W. West Avenue. Wives welcome. Speaker: Herbert A. Wenner, M.D., Kansas City, Kansas. $5.50 per person. Reservations: Harry Waisman, M.D., 1300 University Ave., Madison 6.

6:00 p.m.—WISCONSIN SOCIETY OF ANESTHESIOLOGISTS dinner at the Wisconsin Club. Reservations: Sheldon Burchman, M.D., 250 W. Bergen Court, Milwaukee 17. $7.00 per person, **wives invited.**

7:00 p.m.—WISCONSIN SURGICAL SOCIETY dinner meeting at Milwaukee Athletic Club. Meeting open to all members of the WSS, their guests, and their wives. Reservations: Norman O. Becker, M.D., Secretary-treasurer, 104 South Main St., Fond du Lac

7:00 p.m.—WISCONSIN ORTHOPEDIC SOCIETY dinner at Athletic Club. Speaker: Robert W. Bailey, M.D., Ann Arbor, Mich.

WEDNESDAY, MAY 8

General Scientific Program

PLANKINTON HALL, MILWAUKEE AUDITORIUM

Moderator of the morning session will be A. R. Curreri, M.D., Madison. Out-of-state guest lecturers include: Drs. John Romano, Rochester, Minn.; J. E. Geraci, Rochester, Minn.; and Emil Frei, III, Bethesda, Md.

Special Interest Programs

MILWAUKEE AUDITORIUM

While these programs have been prepared in cooperation with the designated specialty society, all are "open" meetings, and members of the State Medical Society are urged to attend the lectures of greatest interest to them. Each specialty session will start at 2:15 p.m.

OBSTETRICS AND GYNECOLOGY, Plankinton Hall (second floor). Moderator: Ben M. Peckham, M.D., Madison, president of the Wisconsin Society of Obstetrics and Gynecology. Lecturers: Drs. Clyde L. Randall, Buffalo, N. Y.; George S. Kilkenny, Milwaukee; Alex Krembs and Rita Marino, Milwaukee. A business meeting will follow at 4:30 p.m.

PATHOLOGY, Juneau Hall (first floor). Moderator: David J. Carlson, M.D., Milwaukee, president of the Wisconsin Society of Pathologists. Lecturers: Drs. Frank J. Glassy, Sacramento; Charles Altshuler, Paul Kimmelstiel and John Smith, all of Milwaukee, discussants in a panel moderated by Dr D. B. Claudon, Milwaukee.

PSYCHIATRY, North Kilbourn Hall (first floor). Moderator: Charles W. Landis, M.D., Milwaukee, president of the Wisconsin Psychiatric Association. Lecturers: Drs. John Romano, Rochester, N. Y.; Samuel S. Sorkin, Evansville; and David T. Graham, Madison.

RADIOLOGY, Walker Hall (first floor). Moderator: H. H. Wright, M.D., Milwaukee, president of the Wisconsin Radiological Society. Lecturers: Dr. L. A. Davis, Louisville; and E. O. Lipchik, Rochester, N. Y. A business meeting will follow at 4:30 p.m.

A SPECIAL ANNUAL MEETING FEATURE

MEDICAL ART SALON

Milwaukee Auditorium, May 7–8–9

Sponsored by the Woman's Auxiliary of the State Medical Society of Wisconsin

(See the January and February issues of WMJ for details)

THURSDAY, MAY 9

Medical Aspects of Sports

PLANKINTON HALL, MILWAUKEE AUDITORIUM

All physicians in any way associated with high school or college sports are urged to attend this meeting and to participate in the discussion. Program planned cooperatively with Wisconsin Interscholastic Athletic Association and the State Medical Society's Division on School Health of the Commission on State Departments. Morning session will start at 9:00 a.m.

Moderator of the conference will be James C. H. Russell, M.D., Fort Atkinson, a member of the Division on School Health.

Out-of-state guest lecturers are: Dr. Robert W. Bailey, Ann Arbor; and Dr. C. G. Mendelson, Detroit. Discussants are: Drs. James W. Nellen, Green Bay; Frederic W. Reichardt, Stevens Point; Sture A. M. Johnson, Madison; and Donald M. Ruch, Milwaukee.

Special Interest Programs

MILWAUKEE AUDITORIUM AND HOTEL SCHROEDER

While these programs have been prepared in cooperation with the designated specialty society, all are "open" meetings; and members of the State Medical Society are urged to attend the lectures of greatest interest to them. Each specialty session will start at 2:15 p.m.

ANESTHESIOLOGY, Juneau Hall (first floor). Moderator: Harry E. Thimke, M.D., Eau Claire, president of the Wisconsin Society of Anesthesiologists. Guest lecturers: Drs. Robert M. Smith, Boston; and John J. Bonica, Seattle. There will be a joint meeting of the anesthesiologists and pediatricians at 3:45 p.m.

OPHTHALMOLOGY AND OTOLARYNGOLOGY, Hotel Schroeder, East Room (fifth floor). Moderator: William C. Randolph, M.D., Manitowoc, chairman of the Section on Ophthalmology and Otolaryngology. A luncheon will start at 12:15 p.m. followed by a business session and scientific program. Reservations are to be made in advance for the luncheon. Guest lecturers are: Drs. L. R. Boies, Minneapolis; and P. C. Kronfeld, Chicago.

PEDIATRICS, Milwaukee Auditorium, Walker Hall (first floor). Moderator: Thomas V. Geppert, M.D., Madison, president of the Wisconsin Chapter of the American Academy of Pediatrics. Guest lecturers: Drs. H. A. Wenner, Kansas City, Kan.; H. A. Waisman, Madison; Robert M. Smith, Boston. There will be a joint meeting of the pediatricians and anesthesiologists at 3:45 p.m. in Juneau Hall.

SURGERY, Milwaukee Auditorium, Plankinton Hall (second floor). Moderator: A. R. Curreri, M.D., Madison, president of the Wisconsin Surgical Society. Guest lecturers: Drs. Robert W. Bailey, Ann Arbor; G. E. Collentine, Jr., Milwaukee; C. Morrison Schroeder, Milwaukee; Ivan D. Baronofsky, San Diego; and L. W. Worman, Milwaukee. There will be a business meeting of the Surgical Society at 4:15 p.m.

Related Luncheons

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL ALUMNI ASSOCIATION

Tuesday, May 7, 12:15 p.m.
Milwaukee Auditorium, Juneau Hall

Speaker: Major new administrative appointee.
Cost of luncheon: $4.00, including cocktails and service. Make reservations direct to Mr. Ralph Hawley, 418 N. Randall Ave., Madison 5. Make your check payable to U. of W. Medical Alumni Association.

* * *

MARQUETTE UNIVERSITY SCHOOL OF MEDICINE ALUMNI ASSOCIATION

Tuesday, May 7, 12:15 p.m.
Milwaukee Auditorium, Market Hall

Cost of luncheon: $2.50, including service. Make reservations direct to Mr. Ray Pfau, 620 N. 14th Street, Milwaukee 3.

* * *

CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION of the State Medical Society

Wednesday, May 8, 12:15 p.m.
Hotel Schroeder, Pere Marquette Room

Annual Meeting. All officers and county medical society representatives are requested to attend. No charge for the luncheon. Following luncheon there will be a report of Foundation activities and plans for the ensuing year.

* * *

PAST PRESIDENT'S LUNCHEON

Thursday, May 9, 12:15 p.m.
Hotel Schroeder, Parlor G

All past presidents to attend this luncheon. Dr. N. A. Hill, Madison, as immediate past president, will be the host; and Dr. W. J. Egan, Milwaukee, incoming president, will be special guest.

Round Table Luncheons
HOTEL SCHROEDER

TUESDAY, MAY 7

Luncheons will start at 12:15 p.m. Please make reservations in advance. See page 51 for reservation form.

1. **THE ROLE OF THE KIDNEY IN GOUT**
   Richard H. Ferguson, M.D., Rochester, Minnesota
   Chairman: Milton Borman, M.D., Milwaukee

2. **DETECTION OF UTERINE CANCER**
   E. Cuyler Hammond, Sc.D., New York City
   Chairman: R. F. Mattingly, M.D., Milwaukee

3. **RECENT ADVANCES IN THYROID DISEASE**
   George J. Hamwi, M.D., Columbus, Ohio
   Chairman: Edward K. Ryder, Jr., M.D., Madison

4. **SURGERY IN CHRONIC OCCLUSION OF THE FEMORAL ARTERY**
   Ormand C. Julian, M.D., Chicago
   Chairman: James E. Conley, M.D., Milwaukee

5. **DAIRY PRODUCTS IN A DAIRY STATE—OR "TAKING THE BULL BY THE HORNS!"**
   Fredrick J. Stare, M.D., Boston
   Chairman: Warren K. Simmons, M.D., Rhinelander

WEDNESDAY, MAY 8

1. **OBSTRUCTING LESIONS OF THE LOWER URINARY TRACT**
   Elliot O. Lipchik, M.D., Rochester, N. Y.
   Chairman: John Amberg, M.D., Milwaukee
   (Luncheon of Wisconsin Radiological Society, but "open" so long as seating available)

2. **FEVER OF OBSCURE ORIGIN**
   J. E. Geraci, M.D., Rochester, Minnesota
   Chairman: William W. Stead, M.D., Milwaukee

3. **LABORATORY DIAGNOSIS OF COLLAGEN DISEASE**
   Frank J. Glassy, M.D., Sacramento, California
   Chairman: David J. Carlson, M.D., Milwaukee
   (Luncheon of Wisconsin Society of Pathology, but "open" so long as seating available)

4. **THE ELECTIVE INDUCTION OF LABOR**
   Clyde L. Randall, M.D., Buffalo, New York
   Chairman: Ben M. Peckham, M.D., Madison
   (Luncheon of Wisconsin Society of Obstetrics and Gynecology, but "open" to all, so long as seating available)

5. **UNANSWERED QUESTIONS ON "EMOTIONAL CRISES OF PATIENTS AND THEIR FAMILIES"**
   (Based on Morning Lecture)
   John Romano, M.D., Rochester, New York
   Chairman: Charles Landis, M.D., Milwaukee
   (Luncheon of Wisconsin Psychiatric Association, but "open" to all, so long as seating available)

6. **ELECTROCARDIOGRAPHIC PATTERNS IN CHILDREN**
   Richard H. Wasserburger, M.D., Madison

THURSDAY, MAY 9

1. **THE ORTHOPEDIC AND NEUROLOGICAL ASPECTS OF CERVICAL SPINE INJURY**
   Robert W. Bailey, M.D., Ann Arbor, Michigan
   Chairman: Richard C. Wixson, M.D., Madison
   (Luncheon of Wisconsin Orthopedic Society, but "open" to all so long as seating available)

2. **DIAPHRAGMATIC HERNIA**
   Ivan D. Baronofsky, M.D., San Diego, California
   Chairman: J. W. Gale, M.D., Madison

3. **RECENT ADVANCES IN OBSTETRIC ANESTHESIA**
   John J. Bonica, M.D., Seattle, Washington
   Chairman: Harry E. Thimke, M.D., Eau Claire
   (Luncheon of Wisconsin Society of Anesthesiologists, but "open" to all so long as seating available)

4. **E.E.N.T. LUNCHEON**
   Business meeting at 1:00 p.m. with scientific meeting at 2:00 p.m.

5. **THE DIAGNOSIS AND TREATMENT OF GLAUCOMA BY PHYSICIANS IN GENERAL PRACTICE**
   Peter C. Kronfeld, M.D., Chicago
   Chairman: John A. Van Susteren, M.D., La Crosse
   (Luncheon of Wisconsin Society of Public Health Physicians, but "open" to all so long as seating available)

(continued next page)

6. **WARTS: PAST, PRESENT AND FUTURE**

C. G. Mendelson, M.D., Detroit, Michigan

Chairman: Sture A. M. Johnson, M.,D., Madison

(Luncheon of Wisconsin Society of Dermatology, but "open" to all so long as seating available)

7. **PROPER ROLE OF THE PRACTICING PHYSICIAN IN THE USE OF NEW DRUGS**

Ovid O. Meyer, M.D., Madison

8. **MEDICAL TREATMENT OF PEPTIC ULCER**

John F. Morrissey, M.D., Madison

9. **CLINICAL USE OF THE MICROBIOLOGY LABORATORY**

Herbert A. Wenner, M.D., Kansas City, Kansas

Chairman: Thomas V. Geppert, M.D., Madison

(Luncheon of Wisconsin Academy of Pediatrics, but "open" to all so long as seating available)

100 Technical Exhibits

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34 Scientific Exhibits

MILWAUKEE AUDITORIUM

Bruce Hall

GEORGE E. COLLENTINE, JR., M.D.

Chairman Scientific Exhibits

EXHIBIT HOURS

Tues., May 7	8:00 a.m.–5:00 p.m.
Wed., May 8	9:00 a.m.–5:00 p.m.
Thurs., May 9	9:00 a.m.–3:30 p.m.

(Exhibits "break up" at 3:45 p.m. on Thurs., May 9)

IN MAIN EXHIBIT HALL

18–19—PEDIATRIC THORACIC SURGERY PROBLEMS

Drs. J. W. Gale, A. R. Curreri, J. R. Pellett, and G. M Kroncke, Madison

47–48—RENAL–RETINAL PATHOLOGY

Drs. D. A. Roth and B. J. Peters, Wood VA Center, Wood

50—USES AND ADVANTAGES OF BRACHIAL ANGIOGRAPHY

Drs. Marvin Wagner, J. A. Mufson, and A. E. Kagen, Mt. Sinai Hospital, Milwaukee

49—ORTHOPAEDIC SURGERY HARDWARE

Drs. J. R. Stone, Louis Kagen, and P. A. Jacobs, Mt. Sinai Hospital, Milwaukee

49A—TREATMENT OF LYMPHEDEMA OF THE EXTREMITIES

Drs. M. E. Sattler and R. W. Mann, Surgical and Physical Medicine Departments, Mt. Sinai Hospital, Milwaukee

75—PRIMARY MEGALOURETER

Drs. Morris Moel and L. K. Mark, Dept. of Radiology, Mt. Sinai Hospital, Milwaukee

76—TREATMENT OF DIABETES MELLITUS WITH ACETOHEXAMIDE: A CLINICAL STUDY

Dr. E. H. Tashkin, Mt. Sinai Hospital, Milwaukee

76A—DETECTION OF THE METABOLIC PATTERN OF DIABETES MELLITUS IN PREGNANCY: CLINICAL IMPORTANCE

Dr. A. M. Kurzon, Milwaukee

76B—RECONSTRUCTION (BONE) IN ARTHRITIC DISEASES

Wisconsin Chapter, The Arthritis and Rheumatism Foundation, Milwaukee

101—LYMPHOID CELL VARIATIONS IN THE PERIPHERAL BLOOD

Drs. E. L. Bemis, R. S. Haukohl, and Yoshiro Taira, Department of Pathology and Laboratory Medicine, Evangelical Deaconess Hospital, Milwaukee

102—AORTOGRAPHY: METHODS AND VALUE

Drs. R. E. Zellmer and W. E. Deschler, Department of Radiology, Evangelical Deaconess Hospital, Milwaukee

103—ORAL LESIONS AND THE USE OF THE ORAL PAP TEST

American Cancer Society—Wisconsin and Milwaukee Divisions, and Marquette University School of Dentistry

104—TUBERCULOSIS ERADICATION IN WISCONSIN

Wisconsin Anti-Tuberculosis Association

105—UNCOMMON TYPES OF CARDIOMEGALY IN INFANCY

Drs. W. J. Gallen and S. R. McCreadie, Milwaukee Children's Hospital, Milwaukee

106—MODERN TREATMENT OF DUPUYTREN'S DISEASE (PALMAR FIBROMATOSIS)

Drs. W. H. Frackelton and J. L. Teasley, Columbia Hospital, Milwaukee

107—ATHLETIC DERMATITIS

Dr. D. M. Ruch, Columbia Hospital, Milwaukee

108-109—(1) GROSS TISSUE PATHOLOGY DEMONSTRATION

(2) QUALITY CONTROL IN CLINICAL LABORATORY

Wisconsin Society of Pathologists

110-111—NEWBORN SURGICAL EMERGENCIES

Dr. Marvin Glicklich, Department of Surgery, St. Luke's Hospital, Milwaukee

112—LYMPHANGIOGRAPHY: A NEW DIAGNOSTIC AND THERAPEUTIC TOOL

Drs. H. H. Wright, C. E. Schmidt, A. B. Fidler, T. Simonsen, R. G. Evenson, and H. Levinson, Department of Radiology, St. Luke's Hospital, Milwaukee

113—CORRELATION OF X-RAY AND SIGMOIDOSCOPIC FINDINGS IN ULCERATIVE COLITIS

Drs. G. W. Sengpiel, R. T. McCarty, J. J. Wallerius, J. F. Wepfer, and A. E. Fitz, St. Joseph's Hospital, Milwaukee

114—ENVIRONMENT AND CORONARY HEART DISEASE

Dr. T. C. Puchner, St. Joseph's Hospital, Milwaukee

115A—WISCONSIN STATE MEDICAL ASSISTANTS SOCIETY

EXHIBITS AT FOOT OF STAGE

127—FARMERS LUNG

Drs. D. A. Emanuel, B. R. Lawton, F. J. Wenzel, and Charles Bowerman, Marshfield Clinic, Marshfield

128—DIAGNOSIS OF VERTEBRAL LESIONS

Drs. H. C. Hickey and A. J. Jurishica, St. Joseph's Hospital, Milwaukee

129—FUNGI PATHOGENIC TO MAN

Drs. Alexander Berman and D. C. Bleil, St. Michael Hospital, Milwaukee

131—PARACERVICAL BLOCK ANESTHESIA IN OBSTETRICS AND GYNECOLOGY

Drs. H. F. Sandmire and S. D. Austin, Green Bay

132—CULDOSCOPY FOR DIAGNOSIS

Dr. C. J. Levinson, Milwaukee

133-134—WISCONSIN HEART ASSOCIATION

EXHIBITS IN HALLWAY LEADING TO MEETING ROOMS

135—ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

SCIENTIFIC EXHIBITS ON THE STAGE OF BRUCE HALL

- A CENTURY OF SERVICE

  Milwaukee Hospital Medical Staff

- MARQUETTE MEDICAL REVIEW

  Drs. M. J. Dunn and J. W. Fons, Jr., Milwaukee

- TUBERCULOSIS ERADICATION IN WISCONSIN

  Wisconsin Anti-Tuberculosis Association

- DIABETES DETECTION IS IMPORTANT

  Wisconsin Diabetes Association, Wisconsin State Board of Health

- ORAL LESIONS AND THE USE OF THE ORAL PAP TEST

  American Cancer Society — Wisconsin and Milwaukee Divisions, and Marquette University School of Dentistry

- AUXILIARY HOSPITALITY CENTER AND ART SHOW

RESERVATION FORMS FOR

Roundtable Luncheons • Annual Dinner

NOTE: Attendance Limited! Please List 3 Choices for each of the days you make reservations. List in order of preference. $2.50 per luncheon, including gratuities and taxes.

TUESDAY, MAY 7 (See page 169 for listing)

IMPORTANT: Those making reservations for the Marquette and U. of W. Alumni luncheons please make your reservations as indicated and DO NOT INCLUDE WITH THIS RESERVATION.

1. FERGUSON: ROLE OF KIDNEY IN GOUT
2. HAMMOND: DETECTION OF UTERINE CANCER
3. HAMWI: RECENT ADVANCES IN THYROID DISEASE
4. JULIAN: SURGERY IN CHRONIC OCCLUSION OF FEMORAL ARTERY
5. STARE: DAIRY PRODUCTS IN A DAIRY STATE—OR "TAKING THE BULL BY THE HORNS!"

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice: _____

WEDNESDAY, MAY 8 (See pages 171 and 172 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. LIPCHIK: OBSTRUCTING LESIONS OF LOWER URINARY TRACT
2. GERACI: FEVER OF OBSCURE ORIGIN
3. GLASSY: LABORATORY DIAGNOSIS OF COLLAGEN DISEASE
4. RANDALL: ELECTIVE INDUCTION OF LABOR
5. ROMANO: UNANSWERED QUESTIONS ON "EMOTIONAL CRISES OF PATIENTS AND THEIR FAMILIES"
6. WASSERBURGER: ELECTROCARDIOGRAPHIC PATTERNS IN CHILDREN

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice: _____

THURSDAY, MAY 9 (See pages 173 and 174 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. BAILEY: ORTHOPEDIC AND NEUROLOGICAL ASPECTS OF CERVICAL SPINE INJURY
2. BARONOFSKY: DIAPHRAGMATIC HERNIA
3. BONICA: RECENT ADVANCES IN OBSTETRIC ANESTHESIA
4. E.E.N.T. LUNCHEON FOLLOWED BY SCIENTIFIC PROGRAM
5. KRONFELD: DIAGNOSIS AND TREATMENT OF GLAUCOMA BY PHYSICIANS IN GENERAL PRACTICE
6. MENDELSON: WARTS—PAST, PRESENT AND FUTURE
7. MEYER: PROPER ROLE OF PRACTICING PHYSICIAN IN USE OF NEW DRUGS
8. MORRISSEY: MEDICAL TREATMENT OF PEPTIC ULCER
9. WENNER: CLINICAL USE OF THE MICROBIOLOGY LABORATORY

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice: _____

ANNUAL DINNER, Wed., May 8

DANCING
SHORT SPEECHES—COCKTAILS

$7.00 PER PERSON
(Including Gratuities and Taxes)

Number Luncheon Tickets ($2.50 each) . . . . . _____ for $_____

Number Annual Dinner Tickets ($7.00 each) . . _____ for $_____ TOTAL $_____

Make Check Payable to: STATE MEDICAL SOCIETY OF WISCONSIN

NAME _____ STREET _____ CITY _____

(Print, please)

MAIL TO: State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin

Woman's Auxiliary

MRS. E. M. DESSLOCH
Prairie du Chien
State President

MRS. W. D. JAMES
Oconomowoc
President-Elect

PROGRAM HIGHLIGHTS

Friendship "63"

MONDAY, MAY 6

P.M.

3:00—Registration
Main Lobby, Hotel Schroeder

5:30—"Friendship's Moments"
Room 1430, Hotel Schroeder

6:30—Board of Directors' Dinner and Meeting
Club Rooms, Hotel Schroeder

Those who attend:
State Officers, Directors and Chairmen, County Presidents and Presidents-Elect, Past State Presidents, Past National President and Honored Guests

A SPECIAL ANNUAL MEETING FEATURE

HOSPITALITY CENTER AND MEDICAL ART SALON

Milwaukee Auditorium, May 7–8–9

Sponsored by the Woman's Auxiliary of the State Medical Society of Wisconsin

Be sure you visit the Auxiliary Hospitality Center, have a cup of coffee, and review the various watercolor and oil paintings and sculptures of Wisconsin MDs and their wives. BE SURE TO VOTE FOR THE PICTURE AND SCULPTURE WHICH APPEAL TO YOU MOST!

1963 ANNUAL CONVENTION

TUESDAY, MAY 7

A.M.

8:30—Registration
Main Lobby, Hotel Schroeder

9:00—Continental Breakfast
Loraine Room, Hotel Schroeder

9:30—First Business Session
Loraine Room, Hotel Schroeder

P.M.

12:30—"Take Home a Smile" Luncheon
Milano Room, Milwaukee Athletic Club
"The Difference Between Auxiliary Movement Here and in England"
Mr. Gil Hamblet, (Native, Manchester, England)
Manager, Customer Relations
Cook County Credit Bureau, Chicago
(Guest Privileges)

WEDNESDAY, MAY 8

A.M.

8:30—Registration
Main Lobby, Hotel Schroeder

9:00—Continental Breakfast
Loraine Room, Hotel Schroeder

9:30—Second Business Session
Loraine Room, Hotel Schroeder
Memorial Service
Election of Officers
Installation of Officers

P.M.

12:30—"In the Name of Friendship" Luncheon
Coach House Motor Inn
"The Many Faces of Fedicare"
Edward R. Annis, M.D., Miami
President-Elect, The American Medical Association
(Guest privileges)

6:15—RECEPTION OF THE PRESIDENT OF THE STATE MEDICAL SOCIETY OF WISCONSIN
East Room, Hotel Schroeder (fifth floor)

7:15—ANNUAL DINNER OF THE STATE MEDICAL SOCIETY
Crystal Ballroom, Hotel Schroeder (fifth floor)

MRS. C. R. PEARSON
Treasurer
Woman's Auxiliary to the American Medical Association

County Society Proceedings

BROWN

Fifty members of the Brown County Medical Society met January 10 at Green Bay for a dinner and business meeting. The Society's fee schedule committee met prior to dinner. Scientific speaker for the evening was *Dr. J. L. Sims*, professor of medicine at the UW Medical School, Madison. His subject was "The Malabsorption Syndrome."

On March 14 there were fifty members in attendance at the meeting of the Society. The fee schedule committee again met prior to dinner. Speaker for the evening was *Dr. John Koch*, department of anesthesiology, UW Medical School, Madison. He spoke on "Medical Preparation of Patient for Anesthesia." At the business session it was announced that a new series of radio programs on WBAY would be presented by the Society under the direction of *Dr. J. M. Guthrie*. Approval was given for the appointment of a medical committee to advise the Green Bay Vocational School regarding the content of its training program for medical assistants. Members also approved the acceptance of the Medical Self-Help Courses. The Society voted to donate $100 to the Green Bay Science Fund for 1963.

DANE

The February meeting of the Dane County Medical Society was held at the Central Wisconsin Colony, Madison. The program included a brief description of the Colony, its purpose and programs, by Harvey A. Stevens, superintendent, and *Dr. John B. Toussaint*, clinical director; and a talk by Dr. David W. Smith, of the UW Medical School, on "Chromosomal and Genetic Abnormalities in Mental Retardation." Guided tours of the Colony's facilities followed the program.

The March 12 meeting was held in the Presidents' Room of the State Medical Society Headquarters in Madison. Guest speaker was Harry F. Harlow, Ph.D., Department of Psychology Primate Laboratory, University of Wisconsin. His subject was "The Effects of Early Experience on Personal-Social, Heterosexual and Maternal Behavior in Monkeys."

DODGE

The January meeting of the Beaver Dam Medical Forum was held at the home of *Dr. Frederic Haessly*. *Dr. Howard G. Bayley* presented a paper entitled "Can Your Patient Afford It?" The subject completely covered his study of the economic aspects of establishing a radioisotope program in this community—comparing the costs of instituting and maintaining the program to the demand or use that could be made of it. The final analysis related the cost to the patient to the benefit derived by the patient in having these procedures available locally.

DOUGLAS

The Douglas County Medical Society met January 3 at Superior with 19 members present. Dr. John Moyer of Duluth, Minn., was the speaker. His subject was Anemias. *Dr. R. R. Mataczynski*, Superior, was the discussant. Installation of new officers and appointment of committees comprised the business session.

The February 6 meeting was held at Superior with 18 members present. A film on "Oral Diuretics in Clinical Medicine" was presented. At the business session the Society voted to carry out the Sabin Oral Polio Vaccine program in the county on February 23, March 23 and April 27 this year.

Doctor Reardon of Duluth, Minn., was the guest speaker at the March 6 meeting held in Superior. His subject was "Pyelonephritis in Children." *Drs. H. A. Sincock, F. G. Johnson*, and *J. W. Foderick*, Superior, were the discussants. There were 18 members in attendance.

KENOSHA

The regular monthly meeting of the Kenosha County Medical Society was held March 7 at the Elks Club in Kenosha.

LA CROSSE

The La Crosse County Medical Society in December unanimously adopted a resolution to retain the La Crosse County Child Guidance Clinic as a worthwhile program of the County Board. The current budget of $35,000 plus was recommended by the Society to be retained.

On January 21 the Society met in La Crosse. *Dr. George Kroncke* of the University Hospitals, Madison, spoke on "Cancer of the Colon." During the business session the Society voted to carry out a mass polio immunization program on a community-wide basis. Members were also made aware of impending legislation against commercial insurance plans providing payment for blood. This legislation would exclude payment of the administrative cost of blood.

Dr. David Morris, West Salem, was the guest speaker at the February 18 meeting of the Society. His subject was "Cardiac Countershock in Tachycardia." A report on the oral polio immunization program was given during the business session. Forty-four members attended.

Sixty members were present for the March 18 meeting of the Society. Dr. G. K. Stilwell of the Mayo Clinic, Rochester, spoke on "Lymphedema of the Arm." During the business session a recommendation was passed for the drafting of a resolution to the State Medical Society offering La Crosse as the site for the 1964 annual meeting. A report on the

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Physicians whose names appear in italic are members of the State Medical Society.

mass polio immunization program indicated a successful start with 34,000 persons immunized on March 10. Two future clinics have been scheduled for April 21 and June 9.

LANGLADE

Dr. F. D. Bernard, Madison, presented a scientific topic at the December 3 meeting of the Langlade County Medical Society in Antigo. Doctor Bernard, associate clinical professor of surgery at the University of Wisconsin Medical School, talked on "Indications for the Usage of Split Thickness Skin Grafts, Tubes and Flaps." His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from Merck Sharp & Dohme postgraduate program.

OCONTO

New officers of the Oconto County Medical Society are: *Dr. G. R. Sandgren,* Suring, president; *Dr. F. W. Klutzow,* Gillett, vice-president; and *Dr. H. A. Aageson,* Oconto, secretary-treasurer.

ONEIDA–VILAS

Members of the Oneida-Vilas County Medical Society and the Oneida County Bar Association in January held their first joint meeting. A movie answering legal-medical questions was shown following dinner. Physicians attending came from Rhinelander, Tomahawk, Eagle River, and Minocqua.

OUTAGAMIE

Dr. John Huston, associate professor of medicine at Marquette University School of Medicine and member of the Milwaukee County Hospital staff, spoke to members of the Outagamie County Medical Society in January. He discussed the use of closed-chest heart massage and showed a film. Doctor Huston brought a special manikin, equipped with a pressure-measuring device, to help the doctors learn to practice the resuscitation method precisely. His appearance was sponsored by the Wisconsin Heart Association.

OZAUKEE

The Ozaukee County Medical Society met February 28 at Smith Brothers restaurant in Port Washington. *Dr. Nathan Grossmann* of Milwaukee was the guest speaker; he discussed "Cardiopulmonary Diseases." A regular business session followed.

PIERCE–ST. CROIX

The January 22 meeting of the Pierce–St. Croix County Medical Society was held at Rivers Edge, Somerset, for dinner and a business session.

The Society met February 19 at the Hilltop Bowl near Ellsworth. *Dr. E. R. Jonas* was host for the evening, and Doctor Billings of Red Wing spoke on thyroid surgery.

RACINE

The Racine County Medical Society met February 14 for a regular business meeting and dinner at the Dominican College.

RICHLAND

On January 3 Richland County Medical Society met at the Richland Hospital library with 10 members present. *Dr. Karl L. Siebecker* of the University Hospitals, Madison, spoke to the group on "Problems in Anesthesia."

Dr. George B. Murphy of the Gundersen Clinic, La Crosse, spoke to the eight members who attended the March 7 meeting at the Richland Hospital Library. His subject was "Problems in Vascular Surgery."

SAUK

"Obstetrical Emergencies" was the topic discussed by *Dr. W. V. Luetke,* Madison, at the February 12 meeting of the Sauk County Medical Society, held at The Ritz in Baraboo.

Dr. Dean A. Emanuel, Marshfield, spoke on "Treatment of Hypertension" at the March 12 meeting of the Society. During the business session *Dr. J. H. Houghton* of Wisconsin Dells was recommended for reelection as councilor for a three-year term.

TREMPEALEAU–JACKSON–BUFFALO

New officers of the Tri-County Medical Society are: *Dr. Richard Holder,* Black River Falls, president; *Dr. Albert Daniells,* Arcadia, president-elect; *Dr. John Noble,* Black River Falls, secretary-treasurer; *Dr. Elmer Rhode,* Galesville, delegate; *Dr. William Wright,* Mondovi, alternate delegate; *Dr. O. M. Schneider,* Blair, public relations; *Dr. Larry Hanley,* Whitehall, representative to the educational council.

WOOD

The quarterly meeting of the Wood County Medical Society was held February 7 at the Hotel Charles in Marshfield with 35 members attending. During the business meeting *Dr. R. W. Mason,* councilor to the SMS, gave a resume of his activities in connection with the Wisconsin Work Week of Health held February 18–23 at the SMS Headquarters in Madison. The business meeting was followed by a scientific presentation by Dr. A. B. Cameron of the Marshfield Clinic's department of surgery. His subject was "Abdominal Tumors in Infants and Children."

Specialty Society Proceedings

Wisconsin Academy of General Practice

Madison Chapter

A midwinter medical symposium was held February 21 at the Holiday Inn Motel in Madison sponsored by the Madison Chapter of the WAGP. It was supported by a grant from the Merck Sharp & Dohme Postgraduate Program. The program consisted of four topics: "Vaginitis and Its Treatment" by Dr. Edward Banner of the Mayo Clinic, Rochester; "Headaches" by Dr. Benjamin Boshes of Northwestern University School of Medicine, Evanston; "Carotid Artery Insufficiency" by Dr. Robert Siekert of the Mayo Clinic, Rochester; and "Acute Viremias" by Dr. Donald A. B. Lindberg, of the University of Missouri School of Medicine, Columbia. Local arrangements chairman was *Dr. James Moore.*

Milwaukee Oto-Ophthalmic Society

The February 26 meeting of the Milwaukee Oto-Ophthalmic Society was held at the University Club of Milwaukee. Dr. Bertha A. Klien, professor of ophthalmology, University of Chicago, presented the lecture on "Differential Diagnosis of Fundus Lesions."

Dr. T. Manford McGee, chief of the division of otology and director of otology research laboratory, Henry Ford Hospital, Detroit, spoke on "Stapedectomy" at the March 26 meeting of the Society.

Milwaukee Academy of Medicine

The 970th meeting of the Milwaukee Academy of Medicine was held February 19 at the University Club of Milwaukee with members of the Milwaukee Neuro-Psychiatric Society as guests. The scientific topic was "Mechanisms in Cerebrovascular Accidents" which was presented by Dr. Harry M. Zimmerman, chief of the laboratory division of Montefiore Hospital.

The March 19 meeting featured Dr. George F. Cahill, of the department of medicine, Harvard Medical School. His subject was "Newer Concepts of Diabetes."

Wisconsin Psychiatric Association

The fifth annual meeting of the Wisconsin Psychiatric Association was held February 1–3 at the Dell View hotel, Lake Delton. Registration totaled 139 for the three-day event. Theme of the meeting was "The Psychiatric Emergency." *Dr. Gilbert Tybring,* Madison, was chairman of the program.

Election of officers was as follows: president, *Dr. Keith M. Keane,* Appleton; president-elect, *Dr. Robert E. O'Connor,* Madison; secretary, *Dr. Carroll W. Osgood,* Milwaukee; treasurer, *Dr. Edward E. Houfek,* Sheboygan; and councilors, *Dr. Richard R. Teeter,* Milwaukee, and Dr. Herman Gladstone, Madison.

The group also passed a resolution urging support for the research and training programs of the Wisconsin Psychiatric Institute. The resolution urged the people of Wisconsin and the Legislature to support the institute, which was founded in 1915.

The guest list included Dr. Donald Coleman of New York, a featured speaker; Dr. and Mrs. Norman Tabachnick, also a featured speaker; Mr. James Spaulding, of the MILWAUKEE JOURNAL special staff; and Miss Joan McGucken, the Society's newly named executive secretary.

Physicians whose names appear in italic are members of the State Medical Society.

STATE PHYSICIANS GOLF MEET SLATED FOR KENOSHA MAY 23

1963 Spring Tournament of the Wisconsin State Medical Golf Association (WSMGA) at Kenosha Country Club, Thursday, May 23. Golf and dinner. Play starts at 10 a.m. and dinner at 7:30 p.m. $12.00 per participant. Reservation form below can be sent directly to WSMGA, A. H. Luthmers, Executive Secretary, 756 North Milwaukee Street, Milwaukee 2.

I will _____ will not _____ eat lunch at the clubhouse.

I enclose my check for _____ reservation(s) for golf and dinner.

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[1] Best & Taylor, The Physialagical Basis of Medical Practice, Seventh Edition, 1961

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Dr. Dasler Speaks on Rheumatic Fever

Dr. Herbert Dasler, Amery, spoke to the PTA in January. His subject was rheumatic fever. He showed two short movies about the disease and then had a question and answer period.

Attends Dallas Psychiatric Meeting

Dr. Cullen Burris, Milwaukee, attended the National Association of Private Psychiatric Hospitals convention in Dallas, Tex., recently. He reported two significant developments from the meeting: one is the marked increase of interest in involving the entire family of the hospitalized patient into the treatment situation, and two is the increased trend toward psychotherapy discussions in regard to treatment of the hospitalized patient, and less emphasis on drugs and shock.

Dr. I. E. Gaynon Course Instructor

Dr. Irwin E. Gaynon, Milwaukee, will be an instructor for an introductory course in "Expanded Surgery of the Nasal Septum and Closely Related Structures" which will be presented at the Medical College of Virginia, Richmond, April 28–May 1.

Doctor Monk Speaks on Lung Cancer

Dr. Robert S. Monk, Waukesha, spoke to the Optimists Club in Waukesha during January. He urged the Optimists to inform their children of the dangers of cigaret smoking to prevent them from developing a smoking habit.

Dr. C. F. Meyer in New Clinic

Dr. C. F. Meyer moved into a new clinic building in February. The Independence physician leases the building from the I.M.D. Corporation, a nonstock, nonprofit organization consisting of members who contributed various amounts of money to construct the building.

Dr. Kenneth Bill Resigns Position

Increased demands within his own practice and in connection with his position as medical director at the Walworth county hospital and home, have prompted *Dr. Kenneth Bill*, Elkhorn, to resign his position of medical director effective July 1.

UW Physicians Take U. S. Defense Tour

Two physicians represented the University of Wisconsin Medical School during the 1963 Medical Education for National Defense tour in March. They are *Drs. Edwin C. Albright*, assistant dean for clinical affairs at the school, and *Kenneth E. Lemmer*, coordinator at the school. The men visited Brooks Army Medical Center and the School of Aerospace Medicine at Brooks Air Force Base, San Antonio, Tex., and the naval air station and Marine Corps recruit depot, San Diego, Calif.

Physicians whose names appear in italic are members of the State Medical Society.

News of Wisconsin Physicians

Dr. E. D. Sorenson Helps Out

Dr. E. D. Sorenson, Elkhorn, has accepted the position of medical director of the Central Walworth chapter of the American Red Cross on a temporary basis. He replaces *Dr. Kenneth Bill*, who had asked to be relieved of the post, a position he had held since 1950.

Berlin Hospital Medical Staff Named

Officers of the Berlin Memorial Hospital medical staff were elected in January as follows: *Dr. Grant Stone*, president; *Dr. Herman Koch*, vice-president; and *Dr. Erich Schmidt*, secretary. Other members of the staff are *Dr. Lynn Seward* and *Dr. Victor Taugher*, both of Berlin, and *Dr. Russell Darby*, *Dr. Leonard Shemanski*, and *Dr. Francis Slattery*, all of Wautoma.

Dr. M. H. Sahs at Medical Conference

Dr. M. H. Sahs, Hayward, attended a four-day postgraduate conference for general practitioners held in February at the State University of Iowa College of Medicine.

Doctor Andrews Addresses Youth

Dr. George Andrews, Wausau psychiatrist who at one time worked on the staff of Dr. Albert Schweitzer in Africa, was the keynote speaker at the Wisconsin youth committee's district nine conference held in February at Rhinelander. "Youth in Community Affairs" was the theme of the conference which was designed to aid youth and adult groups in organizing more effectively in their communities and counties for greater youth participation and service locally.

Dr. R. J. Samp Speaks on Cancer

Dr. Robert J. Samp, medical director of the Wisconsin Division of the American Cancer Society, Madison, spoke in Whitewater on March 6 on the subject of cancer information: "Facts of Life for Whitewater."

Doctor Turrell Resigns MU Position

Dr. Eugene S. Turrell has resigned as chairman of the psychiatry department of the Marquette University School of Medicine. He will remain on the faculty as a psychiatry professor. Doctor Turrell indicated his resignation was motivated by the gradual location of the chairmen of most other clinical departments of the school at the Milwaukee county hospital, and because of his continuing work at the Chicago Institute of Psychoanalysis.

Doctor LaHam Moves to Three Lakes

Dr. J. T. LaHam, formerly of Ripon, has established his practice at the Three Lakes Clinic. An open house was held in February at the clinic which was just recently built by Mr. and Mrs. Tate Estes as a civic gesture in order to induce a physician to come to Three Lakes.

Medical Staff Election at Neillsville

Dr. Kenneth Manz was named chief of the medical staff of Memorial Hospital at Neillsville in February. Other members of the active staff are: *Dr. M. C. Rosekrans, Dr. T. N. Thompson* and *Dr. M. V. Overman*, all of Neillsville.

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Doctor Henkle Attends Refresher Course

Dr. Robert Henkle, Port Washington, attended a week-long refresher course for general practitioners at the University of Iowa Medical School in February. Doctor Henkle received his M. D. from the university in 1953.

Dr. Norman Engbring Speaks on Diabetes

Dr. Norman Engbring, Milwaukee county hospital, told of "Recent Developments and Research Pertaining to Diabetes" at the Milwaukee Lay society of the Wisconsin Diabetes association on March 13 at the Wauwatosa civic center.

New Medical Staff, Dodgeville Hospital

The January election of medical staff officers for St. Joseph's Hospital, Dodgeville, was as follows: *Dr. D. R. Downs*, Dodgeville, president; *Dr. H. P. Breier*, Montfort, vice-president; and *Dr. S. B. Marshall*, Hollandale, secretary.

To Head Cerebral Palsy Group

Dr. Arthur W. Hankwitz, Whitefish Bay, was elected president of Cerebral Palsy of Greater Milwaukee, Inc., when the group held its annual meeting in January.

Dr. A. A. Lorenz Speaks

Dr. A. A. Lorenz, Eau Claire, spoke on "Rural Safety as Seen by a Psychiatrist" on April 6 at the AMA National Rural Safety Conference in Chicago. Doctor Lorenz is a member of the division on nervous and mental diseases of the Commission on State Departments of SMS. A Wisconsin delegation was in attendance.

Attend Mental Health Conference

Drs. Keith Keane, A. A. Lorenz, L. J. Ganser, Charles Landis, and *Cullen Burris* attended the

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HINSHAW and GARLAND—DISEASES OF THE CHEST—A useful baak unsurpassed far vividness of illustratian and completeness of caverage.

Ninth Annual Conference of State Mental Health Representatives, sponsored by AMA, at the Drake Hotel in Chicago March 1 and 2. Doctor Keane is chairman and Doctor Lorenz is a member of the division on nervous and mental diseases of the Commission on State Departments of SMS. These latter two represented SMS.

Doctor Acheson at Medical Convention

Dr. and Mrs. *Wiliam E. Acheson*, Valders, flew to Los Angeles, Calif., at the end of February so that Doctor Acheson could attend a medical meeting, after which they visited friends and relatives in California.

Opens New Office in Hales Corners

Dr. James A. Clemence, Milwaukee, has opened an office for the general practice of medicine at Hales Corners. He is a 1960 graduate of Marquette University School of Medicine. He took a year's internship at St. Luke's hospital in Milwaukee.

New Pathologist at Kenosha Hospital

Dr. Roy J. Wiarda has joined the pathology staff at Kenosha hospital. Doctor Wiarda came to Kenosha from Rhode Island Hospital, Providence, R. I., where he served a residency in pathology from 1958 through 1962. He received his M. D. degree from the college of medicine at New York University in 1949. He served an internship at E. W. Sparrow hospital, Lansing, Mich. From 1950 through 1958, Doctor Wiarda practiced medicine in Grand Rapids, Mich.

Dr. Philip Zlatnik Opens Office

Dr. Philip Zlatnik, son of *Dr. A. P. Zlatnik*, Two Rivers physician and longtime city health officer, has opened an office in Two Rivers for the practice of thoracic and general surgery. For the past four and one-half years he has been in a residency program at the University of Michigan, Ann Arbor, where he held a faculty position as clinical instructor in surgery the past two years. He is a 1955 graduate of the Marquette University School of Medicine.

Wisconsin Man Air Force Doctor

Dr. James W. Tanner, a graduate of the University of Wisconsin Medical School, has completed his orientation course for officers of the U. S. Air Force medical service at Gunter AFB, Ala. He is the son of Mrs. James W. Tanner of Eau Claire. He has been reassigned to the USAF hospital at Sheppard AFB, Tex. He will join the staff there for practice as a physician.

Dr. Manhart Joins Drs. Land and Scott

Dr. Harold E. Manhart has joined *Dr. James F. Land* and *Dr. John K. Scott* in the practice of ear, nose and throat surgery and medicine in Madison. Doctor Manhart, a 1956 graduate of Ohio State University medical school, is also a clinical instructor in otolaryngology at the University of Wisconsin Medical School and University Hospitals.

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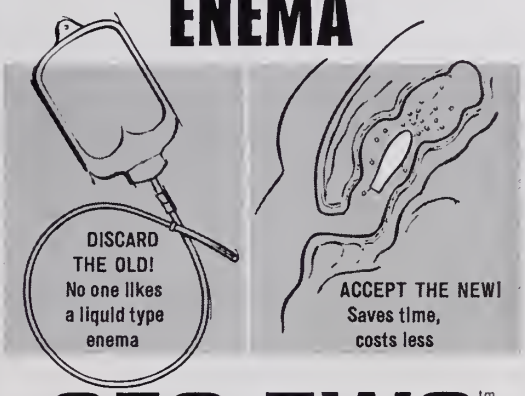

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ACTIVITIES AT STATE MEDICAL SOCIETY HEADQUARTERS

The State Medical Society Headquarters in Madison, at 330 East Lakeside Street overlooking Lake Monona, has been a beehive of activity since the first of the year following completion of the new West Wing which includes a Presidents Room accommodating 200 persons.

One of the major events—and the most ambitious of its kind in Society history—was the Wisconsin Work Week of Health held February 18–23. Purpose of the week-long conferences was to examine the health status of the state, including specific areas which need attention, and the trends and philosophies which will determine Wisconsin's health in the future.

Taking part in the meetings were doctors, lawyers, dentists, nurses, pharmacists, educators, senior citizens, public health officials, industrial leaders, hospital administrators —and a large number of the general public. Over 1,000 persons attended the various sessions. There were 46 state leaders and 22 national experts who participated in the program. Some of these people are shown here.

Top Row: Health of industrial workers was discussed by Dr. Donald M. Ruch, assistant clinical professor of dermatology, Marquette University School of Medicine, Milwaukee; Dr. Gordon W. Petersen, medical director of Kimberly–Clark Corp., Neenah; and John Wrage, director of public relations of Gishalt Machine Company.

Center Row: Fred V. Hein, director of the AMA Department of Health Education, Chicago, Dr. Edward R. Krumbiegel, commissioner of health of the City of Milwaukee, and Dr. N. A. Hill, president of the State Medical Society of Wisconsin, Madison, spoke on health appraisal of school age children at the opening day's session. Dr. H. G. Bayley, Beaver Dam, was one of the many physicians throughout Wisconsin and neighboring states who attended during the week.

Bottom Row: Reuben G. Knutson, member of the Wisconsin Industrial Commission, Madison, and George C. Berteau, director of industrial relations of American Motors Corp., Kenosha, converse over a cup of coffee which was served each day. Dr. Daniel E. Dorchester of Sturgeon Bay, who is chairman of the SMS Commission on Public Relations and Communications, is shown in the background talking with a fellow physician.

Future trends in health care in the Midwest were discussed by presidents of the state medical societies of Wisconsin, Iowa, Illinois, Minnesota and Michigan. Shown above are Dr. George H. Scanlan, Iowa City; Dr. Clarence I. Owen, Detroit; Dr. N. A. Hill, Madison; Dr. George F. Lull, Chicago; and Dr. Donald McCarthy, Minneapolis.

Medical education and hospitals was discussed by Dr. L. O. Skaalen, president of the Wisconsin State Dental Society, Stoughton; Dr. T. H. McDonell, member of the SMS Commission on Hospital Relations and Medical Education, Waukesha; Dr. R. E. Galasinski, immediate past president of The Medical Society of Milwaukee County, Milwaukee; and Dr. J. M. Wilkie, member of the SMS Committee on Occupational Health, Madison.

Wisconsin industry and health was the topic of discussion for speakers Dr. Elston L. Belknap, chairman of the SMS Committee on Occupational Health, Milwaukee; Reuben G. Knutson, member of the Wisconsin Industrial Commission, Madison; Dr. Henry F. Howe, director of the AMA Department of Occupational Health, Chicago; John A. Lawton, attorney specialist in labor law, Madison; and George C. Bertenu, director of industrial relations of the American Motors Corp., Kenosha.

Professional relations between physicians and attorneys was discussed by Dr. W. J. Egan, Milwaukee, president-elect of the State Medical Society; W. Wade Boardman, Madison, legal counsel for the Wisconsin Nurses Association; Robert B. Murphy, Madison, legal counsel for the State Medical Society; and William J. McAuliffe, Jr., Chicago, director of the department of medical ethics of the American Medical Association.

WISCONSIN WORK WEEK OF HEALTH

February 18–23, 1963

Below, top: Mrs. Martha Koepke, R.N., Madison, was one of many who viewed special exhibits on display for the week. Center Row: Dr. Carl N. Neupert, State health officer, Madison, is shown at the left listening to A. Harris Kenyon, director of the Minneapolis district of the Food and Drug Administration, who discussed nutritional quackery. Speaker in the center is Dr. Thomas H. Alphin, director of the Bureau of Medical Services of the Equitable Life Assurance Society, New York City, who discussed insurance and the senior citizen. Looking on during his speech were R. W. Bardwell, chairman of the State Commission on Aging, Madison, and Wilbur J. Schmidt, director of the State Department of Public Welfare, Madison. Bottom: Those who attended the conferences had the opportunity to tour the building to view a number of exhibits depicting medical history, hobbies of physicians, and collections of art including a series of "Medical Still Lifes" by the noted American artist, Aaron Bohrod, who is presently artist-in-residence at the University of Wisconsin. These seven paintings were recently given by the Eli Lilly Company of Indianapolis, Ind., to the SMS Charitable, Educational and Scientific Foundation.

Speakers at the Institute for Hospital Administrators and Chiefs of Medical Staffs were Dr. Kenneth Babcock, director of the Joint Commission on Accreditation of Hospitals, Chicago, and M. H. Albrecht, assistant superintendent of University Hospitals, Madison.

French rural physicians at the Stoughton Community Hospital.

SINCE THE first of the year activities other than the regular and scheduled meetings of various Society committees included an open house for Society employees on January 6, a meeting of executives of health agencies on January 14, a meeting of the Wisconsin Student American Medical Association on February 14, Wisconsin Work Week of Health on February 18–23, including the conference for county medical society presidents and secretaries on February 23 and the Council meeting on February 23–24, a luncheon of the Woman's Auxiliary to the Dane County Medical Society and the Lawyers Wives of the Dane County Bar Association on March 11, a Poison Control Seminar on March 20, a visit by members of the Eau Claire Career Clubs on March 23, a tour by French rural physicians and their wives on March 29, and a Conference on Health Fads and Fallacies on April 18–20.

Workshop session of the Poison Control Seminar.

High school girls from the Eau Claire Career Clubs.

THE STATE Medical Society and its Woman's Auxiliary were hosts and hostesses for a group of 69 French physicians and their wives at an all-day tour March 29. The physicians were members of the French Association of Rural Medicine on tour of the United States. While in Madison the group toured SMS Headquarters, saw a closed circuit tele-

Visits of the French physicians included those to the Stoughton Community Hospital, the medical offices of Doctors Schammel–Hermundstad, Nordhalm, Peterson and Schoenbeck in Stoughton (Doctor Schammel is shown above third from the left, the woman was one of the interpreters), Doctors Kellogg, Dukerschein and Martens in Oregon, Doctors Behrend–Russell, Grob and Nelson in Sun Prairie, the Poser Clinic and Doctor Cheli in Columbus, the East Madison Clinic, Monona Grove Clinic and St. Mary's Hospital in Madison.

The French women, including two physicians, enjoyed brunch at the home of Mrs. John Talbot (Mrs. B. I. Brindley is shown above at the left), and visits to the homes of Mrs. N. A. Hill, Mrs. L. E. Holmgren, Mrs. O. S. Orth, and Mrs. D. L. Williams, all in Madison.

vision program at University Hospitals, toured area physician offices and hospitals, visited several physicians' homes, ate lunch at SMS headquarters, and as a requested sideline visited a "dirt farm." The group was accompanied by four interpreters and an AMA photographer. The trip to Madison was arranged by the AMA.

Obituaries

Dr. Hikmet Aktekin, Superior, died July 26, 1962, at the age of 38.

A native of Nevschir, Turkey, Doctor Aktekin was a 1951 graduate of the Istanbul University in Turkey, and served his internship at that hospital.

After one year in the Turkish Army as a medical officer, he located in the United States, serving his residency in radiology until 1958. Prior to practicing in Superior, Doctor Aktekin spent approximately a year on the Wayne County General Hospital staff in Michigan.

He was a member of the Douglas County Medical Society, State Medical Society of Wisconsin and American Medical Association.

Survivors include his widow and two small daughters, Leyla and Semra, at home.

Dr. Carl W. Eberbach, well-known Milwaukee surgeon, died July 31, 1962, at the age of 72.

Born in Ann Arbor, Michigan, Doctor Eberbach was a 1916 graduate of the University of Michigan Medical School. He interned and served his surgical residency at Barnes Hospital in St. Louis, Missouri.

Prior to his locating in Milwaukee in 1927, Doctor Eberbach served as assistant dean of the medical school and assistant professor of surgery at the University of Michigan; and also served on the hospital staff in Labrador. Locating in Wisconsin in 1928, Doctor Eberbach joined the faculty at Marquette University School of Medicine, and received the appointment there of clinical professor of surgery emeritus in 1960.

A leader in many medical organizations, Doctor Eberbach served on the State Board of Health from 1940–1947, was a past governor and a fellow of the American College of Surgeons, one of the founders and past president of the Wisconsin Surgical Society, and a member of the founders' group of the American Board of Surgery. He also was past president of the Milwaukee Surgical Society, and the Milwaukee Academy of Medicine; and a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Doctor Eberbach is survived by his widow, Elizabeth, and one daughter, Mrs. Harry W. Starr III, Carlinville, Ill.

Dr. Clauss B. Strauch, Hazel Green, died August 21, 1962, at the age of 68.

Born in Germany, Doctor Strauch was educated at the University of Munich. He came to the United States from Berlin, Germany, where he had been assistant professor of surgery at the University of Berlin. He was a practicing physician in New York City and Milwaukee for 13 years before locating in Hazel Green in 1940. Doctor Strauch was head of the Hazel Green hospital, and was credited with enlarging and modernizing that institution.

He held memberships in the Grant County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Helga; three sons, Clauss Jr., at home, Dr. Axel, Riverside, Calif., and Jan, a student at the University of Wisconsin; and a daughter, Mrs. Karen Brown, Ann Arbor, Mich.

Dr. Andrew R. Mailer, former Madison physician, died October 22, 1962, in a Woodstock, Illinois, hospital from injuries sustained in an automobile accident. Doctor Mailer was 64 at the time of his death.

Born in De Pere, Wisconsin, Doctor Mailer received his B. S. degree from the University of Wisconsin in 1922, and his M. D. degree from the Illinois College of Medicine in 1926. After serving for four years as surgeon for the Pan–American Petroleum Corporation, Doctor Mailer returned to the United States where he served a three-year residency in surgery at a Princeton, New Jersey hospital.

Doctor Mailer was a member of the American College of Surgeons, American Fracture Association, and a past member of the Dane County Medical Society and State Medical Society of Wisconsin.

Survivors include his widow and two sons, Andrew Jr., Bethesda, Md., and Stanley H., Madison.

Dr. Robert D. Taylor, 48, a prominent Marshfield physician, died November 11, 1962, in an airplane accident.

A native of Hecla, South Dakota, Doctor Taylor located in Marshfield in 1955. Prior to that time, he was with the Cleveland Clinic in Cleveland. He received his M. D. degree at Northwestern University, his internship was served at Passavant hospital in Chicago, and his residency training taken at Indianapolis General Hospital.

An internist, Doctor Taylor was a life member of the American College of Physicians, and had published more than 50 scientific papers. In 1960, he was chairman of the postgraduate committee of the Wisconsin Society of Internal Medicine. In addition to his Marshfield practice, Doctor Taylor held an associate professorship at Marquette University, and was a staff member at Wood County Hospital.

Societies in which he held membership include the American College of Physicians, American Heart Association, past president of the American Association of Clinical Research, Wood County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow and two daughters, Mrs. Laszlo Babos, Tustin, Calif., and Miss Mary Taylor, Marshfield.

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COST OF PLAN—Single persons pay $7.80 and families $18.00 annually. An additional one-time enrollment fee of $3.00 single and $5.00 family is charged those who do not belong to groups of 25 or more insured persons.

DEDUCTIBLE—There is a $25 deductible each calendar year for each covered member under age 65, and a $50 deductible for each covered member over age 65. A $25 deductible applies to all covered members of groups of 25 and over, regardless of age.

BENEFITS—After the annual deductible is satisfied, WPS will pay contract benefits for charges incurred by a participant for prescription drugs prescribed by a licensed physician for treatment of illness or pregnancy. These drugs may be dispensed and billed by a pharmacist or licensed physician.

Benefits may be paid directly to the pharmacist or physician.

The plan will pay only for prescription drugs which are required by law to bear the legend: Caution—Federal law prohibits dispensing without prescription.

ELIGIBILITY—Any person may apply. The Rx BENEFIT Plan is available on an individual or group basis with the following exception:

Groups and individuals who have Major Medical coverage are not eligible for the Rx BENEFIT Plan because this would be an unnecessary duplication of drug expense benefits already included in their Major Medical coverage.

WAITING PERIODS—There are no waiting periods for the benefits of this policy.

THE DOCTORS' PLAN OF THE STATE MEDICAL SOCIETY

WPS SURGICAL MEDICAL HOSPITAL

WISCONSIN PHYSICIANS SERVICE

330 E LAKESIDE MADISON 1, WISCONSIN ALPINE 6-3101

CALENDAR OF MEETINGS

1963 **Wisconsin**

May 2: Postgraduate course on Common Problems in Ear, Nose, and Throat Arising in General Practice, University of Wisconsin Medical Center, Madison.

May 6–9: State Medical Society of Wisconsin annual meeting, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

May 7: 1963 Metta Bean lecture sponsored by Wisconsin Anti-Tuberculosis Association and University of Wisconsin, by Social Welfare Professor Henry Maas of California, at UW–Milwaukee, student union, Milwaukee.

May 7: One-day institute "Anger At Work", sponsored by Conference Group on Psychiatric Nursing Practice of the Wisconsin Nurses Association, YMCA, Milwaukee. All registered professional nurses invited.

May 8: 1963 Metta Bean lecture by Social Welfare Professor Henry Maas of California, at University of Wisconsin, Wisconsin Center building, Madison.

May 10–11: St. Joseph's Hospital Cancer Symposium, Milwaukee.

May 10–11: Centennial celebration of Milwaukee Hospital. Staff centennial dinner dance May 10 with guest speaker, Edward R. Annis, M.D.

May 11: One-day institute on New Concepts in Orthopedic Surgery, sponsored by Operating Room Nurses Conference Group of Wisconsin Nurses Association, Mercy Hospital, Janesville. Recovery room nurses, central supply room nurses and all other interested nurses invited.

May 11–12: Joint meeting of the Wisconsin, Illinois, and Iowa Associations of Blood Banks, Nippersink Manor, Genoa City.

May 18: One-day institute, "Role That the Office Nurse Can Play in Caring for the Geriatric Patient," sponsored by Office Nurses Section of Wisconsin Nurses Association, Skyline Room, St. Mary's Hospital, Milwaukee. Office nurses invited.

June 7–9: Annual convention of Wisconsin State Medical Assistants Society, Fountain Park Motor Hotel, Sheboygan.

June 13–15: Postgraduate course on Psychoanalysis and Current Biological Thought, University of Wisconsin Center building, Madison.

Oct. 17: Lillie memorial lecture honoring Milwaukee Hospital centennial, by Dr. S. Leon Israel, professor of obstetrics and gynecology, University of Pennsylvania Graduate School, Milwaukee.

Oct. 20–23: Annual District VI meeting of American College of Obstetricians and Gynecologists, Milwaukee.

Nov. 21: Eberbach Memorial lecture honoring Milwaukee Hospital centennial, by Dr. Carl E. Badgley, professor of orthopedic surgery, University of Michigan School of Medicine, Milwaukee.

1963 **Out-of-State**

May 12: Annual meeting of National Tuberculosis Association, Denver, Colo.

May 13–15: Scientific session of National Tuberculosis Association and its medical section, American Thoracic Society, Denver, Colo.

May 20–24: Postgraduate course on Physiological Aspects of Cardiopulmonary Disease, Indiana University School of Medicine, Indianapolis, sponsored by the American College of Physicians.

May 23–24: Thirteenth annual Colorado Intern-Resident Clinics, University of Colorado Medical Center, Denver.

May 24–25: Annual clinical conference of The Chicago Ophthalmological Society, Drake Hotel, Chicago.

June 3–21: 48th session of the Trudeau School of Tuberculosis and Other Pulmonary Diseases, Saranac Lake, N. Y.

July 12–13: Rocky Mountain Cancer Conference, Brown Palace Hotel, Denver, Colo.

June 10–13: Convention of the Catholic Hospital Association of the United States and Canada, Conrad Hilton Hotel, Chicago.

Medical Meetings

Postgraduate Courses

June 13–17: Annual meeting of the American College of Chest Physicians, Atlantic City, N. J.

June 15–16: Second symposium on Anxiety and Depression, sponsored by the Academy of Psychosomatic Medicine, Atlantic City, N. J.

June 16–20: 112th Annual Meeting of the American Medical Association, Atlantic City, N. J.

June 24–28: Postgraduate course on Psychiatry for the Internist, University of Colorado Medical Center, Denver.

June 30–July 1–5: Postgraduate course on Ophthalmology, University of Colorado Medical Center, Colorado Springs.

July 8–10: Postgraduate course on Obstetrics and Gynecology, University of Colorado Medical Center, Denver.

July 15–19: Second International Conference on Congenital Malformations sponsored by The National Foundation–March of Dimes, Americana Hotel, New York City.

July 18–20: Postgraduate course on Dermatology, University of Colorado Medical Center, Denver.

Aug. 5–9: Postgraduate course on Pediatrics, University of Colorado Medical Center, Estes Park.

Aug. 19–23: Medical Audiology Workshop, University of Colorado Medical Center, Denver.

Aug. 26: Annual meeting of American Academy of Physical Medicine and Rehabilitation, Sheraton–Dallas Hotel, Dallas, Tex.

Sept. 16–20: Pulmonary Disease Seminar, University of Colorado Medical Center, Fitzsimons General Hospital, Denver.

Sept. 22–28: XVII World Medical Assembly, Mexico City.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, sponsored by the Council on International Affairs of the American College of Chest Physicians, Mexico City.

Oct. 16–19: Conference on Obstetric, Gynecologic and Neonatal Nursing, sponsored by District VI, American College of Obstetricians and Gynecologists, Chicago.

Oct. 21–22: 1963 Scientific Session of American Cancer Society—A conference on "Unusual Forms and Aspects of Cancer in Man", Biltmore Hotel, New York City.

Oct. 23–25: Chiefs-of-staff Conference, University of Colorado Medical Center, Denver.

Nov. 5–13: Ninth Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Nov. 13–Dec. 10: First Pan-Pacific Mobile Educational Lecture Seminar, New Zealand, Australia, Thailand, the Philippines, Hong Kong and Japan.

State Medical Assistants Society

The ninth annual convention of the Wisconsin State Medical Assistants Society will be held June 7, 8 and 9 at the Fountain Park Motor Hotel in Sheboygan. Physicians who will participate in the program include: Drs. Edward Houfek, Sheboygan; John Hirschboeck, Milwaukee; Herman Heise, Milwaukee; W. W. Bauer, Chicago; Robert Pavlic, Brookfield; and Daniel Dorchester, Sturgeon Bay.

Of special significance to the physician is the symbol

When he sees it engraved on a Tablet of Quinidine Sulfate he has the assurance that the Quinidine Sulfate is produced from Cinchona Bark, is alkaloidally standardized, and therefore of unvarying activity and quality.

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OFFICIAL NOTICE

TO MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Pursuant to the requirements of the Constitution and Bylaws of the State Medical Society of Wisconsin, the following amendments to the Constitution, as introduced at the 1962 session of the House of Delegates, are being published in the March and April, 1963, issues of the *Wisconsin Medical Journal.*

Constitutional Amendments Introduced in May 1962 for action in May 1963

Note: Material to be deleted is in parentheses; new material is in italic. The Constitution and Bylaws were published on pp. 57–64 of the January 1963 Blue Book issue of the *Wisconsin Medical Journal.*

Amend Article VI of the Constitution as follows:

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The (president, the) president-elect, the secretary, *and* the treasurer (and the speaker of the House of Delegates) shall be ex officio members of the Council, but without the right to vote, *and the president and speaker of the House of Delegates shall be ex officio members with such right to vote.* (Nine) *A majority* of its *voting* members shall constitute a quorum.

Amend Section 1 of Article IX of the Constitution by addition of the following paragraph:

No person shall hold more than one of such offices concurrently.

Amend the first paragraph of Section 2 of Article IX of the Constitution as follows:

The officers, except the councilors *and the speaker of the House of Delegates,* shall be elected annually. *The term of the speaker shall be for two years.* The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

Classified Advertisements

Advertisements in this section are accepted in two categories: PHYSICIANS' EXCHANGE and COMMERCIAL.

RATES: 10¢ per word, with a minimum charge of $4.00 per ad. Additional insertions of same ad at one-half price each, maximum time one year. Display: $10.00 per column inch.

DEADLINE: Copy must be received by the 15th of the month preceding month of issue. Send copy to: Wisconsin Medical Journal, Box 1109, Madison 1, Wis.; or phone ALpine 6–3101.

PHYSICIANS' EXCHANGE: This section is limited to physicians and others desiring physician placement, sale of medical practice or equipment of a physician, sale or lease of medical buildings, etc. Advertisements from individual members of the State Medical Society of Wisconsin are accepted without charge. Widows of deceased member physicians are allowed to advertise without charge. The rates quoted above apply to ads placed by clinics and others. There is no additional charge for ads with Dept. numbers. For these ads, address replies to: Dept. ___, % Wisconsin Medical Journal, Box 1109, Madison 1, Wis. Advertisers using Dept. numbers forbid the disclosure of their identity. All inquiries are forwarded to them immediately.

COMMERCIAL: Advertisements are accepted at the above rates from individuals, firms, organizations, etc., who are reputable, have a good credit rating and advertise products or services of ethical standards. The Journal reserves the right to reject any advertising. Advertisements from member physicians are also accepted at the above rates.

PHYSICIANS' EXCHANGE

WANTED: PSYCHIATRISTS or young doctors, interested in psychiatry to work at Mendota State Hospital. These positions are permanent and under Civil Service; salary depends upon previous experience and training. Housing available on grounds. Contact W. J. Urben, M.D., Superintendent, Madison 4, Wis. g10tfn

FOR SALE: UNOPPOSED small town general practice, southwestern Wisconsin. Modern, well equipped, air conditioned building, excellent open staff hospital nearby. Annual gross over $50,000. Contact Dept. 999 in care of the Journal. m8tfn

WANTED: Certified or qualified specialist in—

1. Psychiatry
2. Neurology
3. Plastic Surgeon
4. Neurosurgeon
5. Pathology
6. Anesthesiology
7. Ophthalmology
8. Proctology

also Registered Pharmacist and EEG Technician to join 27-man, all-specialist group. Contact Harold E. Scherer or Robert G. Zach, M.D., The Monroe Clinic, Monroe, Wis. 4tfn

FOR SALE: Established EENT practice, over 40 years in the heart of Milwaukee. Excellent referrals; will introduce; retiring. Contact Dept. 24 care of the Journal. m12tfn

OFFICE SPACE for two or three physicians, OB or two surgeons. To rent or to sell. Pharmacy in same building. Contact Dept. 33 in care of the Journal. m3tfn

WANTED: GENERAL PRACTITIONER as associate. Immediately available opportunity to practice in well established group of two. Replacement for sudden loss of partner. Eventual partnership. 126 E. Main Street, Madison. AL 6–3171. m9tfn

PEDIATRICIAN desires association with a group or another pediatrician. Contact Dept. 47 in care of the Journal. m4–5

WANTED IMMEDIATELY: Young general surgeon (Board eligible or Board certified) to practice with 5-man group which includes 4 GPs and a radiologist, in new 6,000 sq. ft. clinic building, in college town of approximately 5,000 located 30 miles from Twin Cities. Excellent starting salary with early partnership.

ALSO WANTED: Young GP to associate with above group. Excellent starting salary with early partnership. Contact Edward A. Jenkins, Manager, River Falls Medical Clinic, Ltd., River Falls, Wis. 4tfn

WANTED: GENERAL PRACTITIONER as a replacement in town of 1,275 in southern Wisconsin. Gross receipts $42,000 in 1961, over $24,000 first 6 months 1962. Unopposed, good schools, churches, roads, fishing. Nearby accredited 200 bed hospital. Leaving for residency. Contact: D. L. Minter, M.D., Clinton, Wis. m9tfn

MEDICAL SUITE: Ozaukee Medical Center, Thiensville, Wis. Two doctors' offices, four examining rooms, lead line x-ray room, laboratory, general office and waiting room. Heating and air conditioning furnished by owner. Available Nov. 1, 1963. Phone CHestnut 2–1080 or CHestnut 2–2344. E. C. Neidner, 231 South Main St., Thiensville, Wis. 4tfn

FOR SALE: Two level home and office on bank of river; 45-acre estate near town of 6,000. 70 miles north of Madison. Hospital, good schools, several churches. Man with surgical training desirable. Purchase may be made by land contract. Might consider a locum tenens with potential permanent arrangement. A highly flexible opportunity for the right person. Contact Dept. 23 in care of the Journal. m12tfn

WANTED: INTERNIST, Board certified, to join two established surgeons. Excellent office facilities. Opposite 300-bed hospital—200-bed added expansion in progress. Town of 15,000. Central Wisconsin. Guaranteed salary. Percentage and partnership early prospects. Contact Paul F. Doege Medical Center, 512 St. Joseph Ave., Marshfield, Wis. m3tfm

WANTED: GENERAL PRACTITIONER for association with two-man group located near Madison. Excellent hospital and recreational facilities. Salary open to start with partnership opportunity at end of one year. New building with excellent equipment and personnel. Contact Dept. 51 in care of the Journal. m4tfn

WANTED: PEDIATRICIAN for newly organized group in Fox River Valley of Wisconsin. One other pediatrician in community of 45,000. Excellent living conditions, noted recreational area and above average opportunity. Salary two years, then partnership. Contact Dept. 6 in care of the Journal. m9tfn

GENERAL PRACTICE FOR SALE. Physician desiring own x-ray equipment may purchase radiographic, fluoroscopic and therapy equipment. Seven-room office on main corner in southern Wisconsin city of 35,000 occupied for over 40 years. Wish to retire. Reasonable price. Contact Dept. 19 in care of the Journal. m11tfn

PARTNER IN GENERAL PRACTICE WANTED in Green Lake county, town of 5,000. Fifty-bed private hospital. Five grade schools and one high school. No predominant nationalities. Various churches. Main occupations are leather, fur and metal. Contact Dept. 20 in care of the Journal. m11tfn

WANTED: PHYSICIAN with military service fulfilled to associate with a general surgeon also in general practice in northeastern Wisconsin in a city of 75,000. Excellent salary leading to early partnership. This is an A-I financial opportunity. An early interview is appreciated. Contact Dept. 43 in care of the Journal. m4tfn

URGENTLY NEEDED: Associate going for residency—another man urgently needed. Twelve miles east of Fond du Lac, Catholic rural area. Start at $1,300 or more monthly. No investment. Available June. Contact Jos. F. Miller, M.D., Mt. Calvary, Wis. m4tfn

WANTED: INTERNIST, Board certified or eligible for association with young internist in southeastern Wisconsin city of 90,000. Contact Dept. 980 in care of the Journal. m4tfn

FOR SALE: IN WISCONSIN. General practice, well established, same location 40 years, fully equipped 7-room office. Will take any reasonable offer and finance as you wish. Poor health forces retirement. Contact Dept. 912 in care of the Journal. m4tfn

WANTED: PHYSICIAN to share a clinic which is now occupied by an M.D. and a D.D.S., located in a prosperous southeastern Wisconsin industrial and farming community where the need for another physician is very great. Contact Dept. 827 in care of the Journal. 4tfn

FOR SALE: PEDIATRICS PRACTICE in suburb of large Wisconsin city; will introduce; buyer assume two-year lease; open hospital staff; physician leaving Sept. 1, 1962, for academic post. Contact Dept. 985 in care of the Journal. m5tfn

ST. PAUL: General practitioner needed to fill third position with two 39-year-old AAGP members. Own beautiful, air-conditioned office building. Salary related to experience and early partnership desired. Contact Dept. 49 in care of the Journal. 4–6

WANTED: GENERAL PRACTITIONER to become associated with small group in central Wisconsin, preferably one who has had some practical experience, and has a special interest in obstetrics; also willing to only assist in surgery. Contact Dept. 969 in care of the Journal. m2tfn

ADDITIONAL OBSTETRICIAN–GYNECOLOGIST for northern Minnesota general practice and specialty group. Early partnership. Contact A. M. Antonow, M.D., East Range Clinic, Virginia, Minn. 4–6

OFFICE SPACE in medical clinic, 2218 North Third Street, Milwaukee, Wis.; Co. 4–2800. m3tfn

WANTED: GENERAL PRACTITIONER to replace physician who left for residency training. Fully equipped office available immediately. Town of 2,100 offers good hospital, skiing, hunting, golf, fishing and many other recreational advantages along the Chippewa River near its junction with the Mississippi. Financial remuneration should be excellent from the start. Contact Dept. 7 in care of the Journal. m9tfn

WANTED: GENERAL PRACTITIONER for associate with two other general practitioners in community of 2,400 with trade area of 7,000 in Green county. No investment required. Excellent clinical and diagnostic facilities. 200 bed hospital 15 miles. Good educational facilities. Convenient communications to recreational areas. Contact M. W. Stuessy, M.D., Brodhead. m3tfn

GENERAL PRACTICE available immediately in Milwaukee, Wis. (southeast side). Established 35 years, busy active practice, excellent location, beautiful ground floor clinic building, air-conditioned. Contact Dept. 41 in care of the Journal. m4tfn

GENERAL PRACTICE for sale in southeastern Wisconsin. Active practice of 13 years standing. For price of equipment and real estate. Air-conditioned first floor office, 1800 sq. ft. Supplementary rental income from three dental offices upstairs. City 3,500, drawing area 6,000. Open staff hospitals nearby. In fishing, hunting area. One hour away from State's largest cities for shopping, cultural activities. Contact Dept. 42 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER with some general surgical training to associate with another physician. Beautiful, large, new, well-equipped office. Parking lot. Air-conditioned. Starting salary $1,000. Partnership. City 10,000; drawing area 20,000. North Central Wisconsin. Contact Dept. 46 in care of the Journal. m4tfn

GOOD LOCATION AVAILABLE for general practitioner. Nothing to buy. Will assist and refer all general practice cases. Contact C. A. Sholtes, M.D., Richland Center, Wis., Midway 7–2592 or 7–2544. m9tfn

FOR SALE: GENERAL PRACTICE, well trained and active, in new fully equipped clinic building. Present physician leaving for residency. Personnel well trained and efficient. Rural village 38 miles northeast of Madison. New school, swimming pool, good housing available. Subsidy can be arranged through village. Contact Joseph G. Brown, M. D., Cambria, Wisconsin. m6tfn

FOR SALE: GENERAL PRACTICE in Chippewa Falls, Wis.; well established, same location for 17 years, fully equipped 5½-room office. Will take any reasonable offer and finance as you wish. Office help available. Practice available because of recent death of William F. Janc, M.D. Contact Mrs. William F. Janc, 300 Macomber Street, Chippewa Falls, Wis. m7tfn

PHYSICIANS, with or without pediatric training, needed in maternal and child health program at salaries ranging from $9,960.00 to $13,200.00. Five-day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, Milwaukee Health Department, Municipal Building, Milwaukee 2, Wis. g8tfn

WANTED: GENERAL PRACTITIONER as associate in a four-man group with adequate clinical facilities. Offer open for two or three year locum tenens or for permanent association in the group. Town of 4,000, well-equipped 80-bed hospital, in west central Wisconsin. Contact Dept. 10 in care of the Journal. m9tfn

EENT SPECIALIST NEEDED for Eau Claire and vicinity, population 60,000. Could take over 20-year practice of deceased physician. Very advantageous opportunity. Contact Mrs. S. B. Russell, 114½ Grand Avenue West, Eau Claire, Wis. m3tfn

WANTED: USED EQUIPMENT of a physician. Young physician establishing private practice in Madison interested. Contact Dept. 34 in care of the Journal. m3tfn

WANTED: LOCUM TENENS for the month of May. Will pay $1,000 for the month, but person must find own living quarters. Physician who seeks locum tenens will be available part of the time during the month. Contact Dept. 35 in care of the Journal. m3–4

GENERAL PRACTITIONERS for psychiatric treatment center. Present salary range $10,896–$14,196 with possibility of legislative increase July 1, 1963. Excellent comprehensive fringe benefit program, 40-hour week and limited furnished housing for single physicians or small families available at nominal cost. Please contact W. J. Urben, M.D., Superintendent, Mendota State Hospital, 301 Troy Drive, Madison, Wis. g4tfn

URGENTLY NEEDED: General Practitioner to become associated with small clinic group in Milwaukee, Wis., preferably one who has had practical experience and a special interest in obstetrics or industrial surgery. First year, salary; then profit percentage leading to partnership. Contact Dept. 48 in care of the Journal. m4tfn

GROUP OF THREE desires general practitioner as associate. New clinic building with adequate facilities, in town of 5,500. Recent graduate preferable. Contact Plymouth Clinic, Plymouth, Wis. m4tfn

WANTED: Two young general practitioners to join 5-man group. Salary to start, early partnership western Wisconsin college town. Excellent hospital. Unlimited recreational facilities. Contact Dept. 50 in care of the Journal. 4–6

LOCATION WANTED: Either general practice or radiology or combination. Board eligible in radiology and experienced GP. Will serve several small hospitals in radiology, or will purchase retiring physician's equipment. Contact Dept. 51 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER, immediate full partnership in active practice now grossing $50,000, all advantages of dual practice with vacation periods and free weekends. No investment required. Full hospital privileges. Contact Dept. 52 in care of the Journal. m4tfn

ALLERGIST WANTED to share offices with dermatologist. Located in thriving area, south central Wisconsin. Unusual opportunity. Applicant must be board certified or qualified and intending to become certified. Reply, with details of personal and professional qualities and qualifications, to Dept. 5 in care of the Journal. m8tfn

TWO INTERNISTS WANTED: Unusual opportunity to join a young multi-specialty group. Salary $18,000 first year with rapid acceleration to partnership. Exceptional clinic and hospital facilities in Midwest town of 30,000 which is the Medical Center of large trade area and a fine place to raise a family. Contact Dept. 44 in care of the Journal. 4–6

WANTED: INTERNIST for newly formed professional corporation in northeastern Wisconsin. Ideal living conditions and superior opportunity for advancement. Salary during first two years of association. Contact Dept. 25 in care of the Journal. 1tfn

OUTSTANDING OPPORTUNITY for a young physician who is willing to work. Good schools, good 100-bed hospital. Good fishing and hunting. Retiring. Contact Dept. 32 in care of the Journal. m2–3

FOR RENT: OFFICE SPACE, 1200 sq. ft., for medical offices in modern, air-conditioned building at 16 East Gorham Street, Madison. Available for immediate occupancy. Will accommodate one or two physicians, preferably internists. Off-street parking. Contact Robin Allin, M.D., 1313 Fish Hatchery Road, Madison, Wis., phone ALpine 6–5521; or residence CEdar 3–2082. m8tfn

HELP! Two-man practice with only one man! General practitioner. Small town. Salary first year; partnership later. T. S. Westcott, M.D., 115 West Chestnut St., Pardeeville, Wis. m3tfn

GENERAL PRACTITIONER desires associate or partner. Liberal terms. No down payment. Two open staff hospitals. Plenty of work and plenty of recreational opportunities. A. B. Kores, M.D., Beaver Dam, Wis. m3tfn

WANTED: GENERAL PRACTITIONER or man with specialty who will do general practice and associate with one or two other men in well established practice. Fox River Valley. Immediate opening. Community of 50,000. Salary two years, then partnership. Contact Dept. 38 in care of the Journal. m4–5

WANTED: OPHTHALMOLOGIST for newly organized group in the Fox River Valley of Wisconsin. Community of over 50,000. Excellent living conditions, noted recreational area and above average opportunity. Salary two years then partnership. Contact Dept. 45 in care of the Journal. 4tfn

WANTED: GENERAL PRACTITIONER to join general practitioner in well established practice in southeastern Wisconsin. Town of 8,000. Class A accredited hospital. Salary or partnership if mutually agreeable. Contact Dept. 39 in care of the Journal. m3–5

WANTED: GENERAL PRACTITIONER to replace retired physician in established three-man group. Must be interested in general medicine, obstetrics, and willing to assist in surgery. Fully equipped medical suite including x-ray and laboratory in town of 50,000 in Fox River Valley of Wisconsin. Unusual opportunity with eventual partnership. Contact Dept. 36 in care of the Journal. m3tfn

WANTED: GENERAL PRACTITIONER to join physician in a large medical and surgical practice. Newly constructed clinic and 30-bed hospital. Beginning salary: $15,000 annually plus percentage. Good agricultural and industrial small town in the heart of Wisconsin. Finest recreational areas yet extremely close to the twin cities, Minneapolis and St. Paul. Contact Dept. 37 in care of the Journal. m3tfn

PHYSICIAN WANTED: General practitioner in northeastern Wisconsin wants part time help. Can use one man or combination to cover practice for week, month, or up to a year. Money no object for right man. No OB or surgery unless desired. Living facilities and car available. Contact Dept. 29 in care of the Journal. m1tfn

FOR SALE: Genophthalmic chair, Genophthalmic refractor, Claison projector, eye glass display cabinet, treatment table, records from eye, ear, nose and throat practice—42 years. Price very reasonable. J. J. Sharpe, M.D., 150 E. First St., Fond du Lac; telephone 291 and 349. m3tfn

WANTED: PHYSICIAN to associate with two established general practitioners in southeastern Wisconsin industrial, agricultural community of 6,000. Prefer one who has had special surgical training and willing to do general practice along with surgery. Contact Dept. 31 in care of the Journal. m1–3

WANTED: Young, ambitious general practitioner needed at once at the Janesville Medical Center, 2020 E. Milwaukee St., Janesville, Wis. Salary for first year; and if mutually agreeable after one year, may become partner. Contact Duane F. Alexander, Business Manager. 3tfn

PSYCHIATRIC RESIDENCIES available for July 1963: Approved three-year progressive program near Detroit. University affiliations. Teaching staff of Board men, professors, psychoanalysts, nationally known visiting lecturers. Active research. Personal and training analysis available in Detroit. Modern physical plant. Stipends: first year, $7,517; second year, $7,851; third year, $8,519 plus liberal vacation, sick leave, insurance benefits. GPs may apply for NIMH grant with stipends of $10,000–$12,000. Five-year career program with salary to $12,570 also available. Write: Philip N. Brown, M.D., Supt., Northville State Hospital, Northville, Mich. 4–6

WANTED: YOUNG GENERAL SURGEON for associate leading to partnership in one year if mutually agreeable. Mideastern Wisconsin. Contact Dept. 9 in care of the Journal. m9tfn

COMMERCIAL

WANTED: Advertisements for this new section. Open for physicians, individuals, firms, organizations who have something they would like to sell, or are looking for something to buy, or have a service available, which might be of interest to physicians.

The State Medical Society of Wisconsin

ORGANIZED 1841

N. A. HILL, Madison, President
W. J. EGAN, Milwaukee, President-elect
R. E. CALLAN, Milwaukee, Speaker
H. W. CAREY, Lancaster, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

J. C. FOX, La Crosse, Chairman
J. M. BELL, Marinette, Vice-chairman

Term Expires 1963

First District:
W. D. James.....Oconomowoc

Second District:
G. J. Schulz.....Union Grove

Term Expires 1965

Third District:
M. D. Davis.....Milton

Term Expires 1964

E. J. Nordby.....Madison

Term Expires 1963

J. H. Houghton.....Wisconsin Dells

Term Expires 1964

Fourth District:
E. M. Dessloch.....Prairie du Chien

Term Expires 1964

Fifth District:
P. B. Blanchard.....Cedarburg

Sixth District:
H. J. Kief.....Fond du Lac

Term Expires 1965

George Nadeau.....Green Bay

Seventh District:
J. C. Fox.....La Crosse
(Chairman)

Eighth District:
J. M. Bell.....Marinette
(Vice-chairman)

Ninth District:
R. W. Mason.....Marshfield

Tenth District:
R. C. Frank.....Eau Claire

Term Expires 1963

Eleventh District:
V. E. Ekblad.....Superior

Twelfth District:
L. J. Van Hecke.....Milwaukee
W. J. Houghton.....Milwaukee

Term Expires 1964

D. M. Willson.....Milwaukee

Term Expires 1965

S. L. Chojnacki.....Milwaukee
S. W. Hollenbeck.....Milwaukee

Thirteenth District:
W. P. Curran.....Antigo

Term Expires 1963

L. H. Lokvam.....Kenosha
(Past President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

L. O. Simenstad, Osceola, 1964
E. L. Bernhart, Milwaukee, 1964
R. E. Galasinski, Milwaukee, 1963
A. A. Quisling, Madison, 1963

Alternates

John M. Bell, Marinette, 1964
C. J. Picard, Superior, 1964
George Collentine, Jr., Milwaukee, 1963
W. B. Hildebrand, Menasha, 1963

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	Wm. Smiles 522 W. 2nd St., Ashland	C. A. Grand 206–6th Ave., W., Ashland	
Barron–Washburn–Sawyer–Burnett	D. G. MacMillan Barron	J. K. Hoyer 40 W. Newton, Rice Lake	Second Tuesday 7:30 p.m.
Brown	John E. Dettman 519 S. Monroe Green Bay	Frank Urban Rm. 308, City Hall, Green Bay	Second Thursday*
Calumet	K. R. Humke Chilton	R. E. Knauf Chilton	
Chippewa	G. C. Shonat 100½ Bridge, Chippewa Falls	C. T. Bowe Cadott	Second Tuesday
Clark	E. Dolf Pfefferkorn Colby	Bahri Gungor Loyal	
Columbia–Marquette–Adams	R. T. Cooney 310 W. Conant St., Portage	J. W. Pavelsek, Jr. 310 W. Conant St., Portage	Every Third Month 7:00 p.m.
Crawford	M. S. Garrity 610 East Taylor St., Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	R. N. Allin 1313 Fish Hatchery Rd. Madison	Gordon Davenport 110 E. Main, Madison	Second Tuesday**
Dodge	Fred A. Karsten 514 E. Lake St., Horicon	Norman Erickson 302 N. Spring St., Beaver Dam	Last Thursday*
Door–Kewaunee	Patricia Lanier Kewaunee	E. W. Wits 213 Ellis, Kewaunee	
Douglas	L. R. Rosin 2231 E. 5th St., Superior	Enzo Krahl 324 Board of Trade Bldg. Superior	First Wednesday* Hotel Superior
Eau Claire–Dunn–Pepin	R. R. Richards 605 Walker Ave., Eau Claire	W. H. Walter 131 S. Barstow St., Eau Claire	Last Monday
Fond du Lac	C. M. Flannagan 80 Sheboygan St. Fond du Lac	W G. Kendell 92 E. Division St., Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley, Wabeno	D. V. Moffet, Crandon	
Grant	C. L. Steidinger Platteville	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	W. J. Fencil 921 16th Ave., Monroe	B. H. Brunkow 921 16th Ave., Monroe	
Green Lake–Waushara	Grant Stone 124 N. Wisconsin, Berlin	L. J. Seward 147 N. State St., Berlin	Last Thursday, every other month starting in Jan.

* Except June, July and August. ** Except July and August

List of Officers and Scheduled Meetings of County Medical Societies (Continued)

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	David Downs Dodgeville	E. J. Hohler Mineral Point	First Thursday following first Monday
Jefferson	E. A. Miller 133 Riverlawn Ave. Watertown	J. S. Garman 144 W. Madison, Waterloo	Third Thursday°
Juneau	J. H. Vedner Mauston	Jack Strong Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	J. J. Lutz 1202 60th St., Kenosha	G. F. Armstrong 6530 Sheridan Rd., Kenosha	First Thursday° Elks Club
La Crosse	George Skemp 312 State St., La Crosse	Ruth Dalton St. Francis Hosp., La Crosse	Third Monday
Lafayette	R. E. Hunter Argyle	L. L. Olson Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	John McKenna 1125 Superior, Antigo	First Monday
Lincoln	J. D. Millenhah 121 S. Mill St., Merrill	E. O. Ravn, Jr. 1802 9th St., Merrill	
Manitowoc	R. G. Yost 918 Washington St. Manitowoc	S. L. Kaner 1421 17th St., Two Rivers	Last Thursday
Marathon	R. H. Brodhead Box 838, Wausau	George Kordiyak 126 Grand Ave., Wausau	
Marinette–Florence	R. J. Maginn 1232 Mill St., Niagara	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	R. A. Frisch 425 E. Wisconsin Ave., Milwaukee	W. C. Curtis 9128 W. North Ave., Wauwatosa Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milw.	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	G. R. Sandgren Suring	H. A. Aageson 1113 Main St., Oconto	
Oneida–Vilas	Allen Johnson Rhinelander	Marvin Wright 1020 Kabel Ave., Rhinelander	Monthly
Outagamie	F. M. Hauch 722 W. Lawrence St., Appleton	Wm. Chandler 402 W. Wisconsin, Appleton	Third Thursday° Elks Club
Ozaukee	R. F. Henkle 549 W. Grand Ave., Port Washington	P. W. Wallestad 502 W. Jefferson, Port Washington	
Pierce–St. Croix	H. J. Laney Prescott	P. H. Gutzler River Falls	Third Tuesday
Polk	Donald Fink St. Croix Falls	Lloyd L. Olson St. Croix Falls	Third Thursday 7:00 p.m.
Portage	Walter Gramowski 319½ W. Main St. Stevens Point	Albert Kohn 313 N. Fremont Stevens Point	
Price–Taylor	Walter E. Niebauer Phillips	John L. Rens Phillips	Last Saturday, Feb., May, Aug., and Nov.
Racine	W. H. Williamson 1101 Grand Ave., Racine	L. E. Jones 431 15th St., Racine Mr. G. N. Geraghty 600 Villa Street, Racine Exec. Sec.	Third Thursday
Richland	R. W. Edwards 118 West Mill St. Richland Center	L. M. Pippin 323 South Central Ave., Richland Center	First Thursday Richland Hospital
Rock	R. M. Baldwin 419 W. Pleasant St., Beloit	W. A. Scholten, Jr. 1146 Grant, Beloit	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	H. P. Baker Wonewoc	R. G. Knight 244 E. Main St., Reedsburg	Second Tuesday°
Shawano	H. F. Laufenberg Shawano	A. J. Sebesta Shawano	Third Wednesday
Sheboygan	Arthur C. Tompsett 920 Huron Ave., Sheboygan	J. F. Kovacic 708 St. Claire Ave., Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	Richard L. Holder 221 Main St., Black River Falls	J. H. Nohle 1109 Harrison Black River Falls	Fourth Tuesday
Vernon	Roy B. Balder, Jr. Elroy	C. A. Ender Viroqua	Last Wednesday
Walworth	Henry Mol Elkhorn	Rocco S. Galgano 610 Walworth, Delavan	Second Thursday°
Washington	Wm. C. P. Hoffmann 57 S. Main St., Hartford	James Algiers P. O. Box 110, Hartford	Fourth Thursday
Waukesha	Robert Feulner 630 Oxford Rd., Waukesha	W. E. Rosenkranz 720 N. Rochester, Mukwonago	First Wednesday
Waupaca	George Dernhach New London	Lloyd P. Maasch Weyauwega	
Winnebago	R. H. Quade 116 So. Commercial St., Neenah	E. J. Zmolek 302 N. Main St., Oshkosh	First Thursday
Wood	F. John Gouze 650 S. Central Ave., Marshfield	John W. Rupel 650 S. Central, Marshfield	Four times a year

° Except June, July and August. °° Except July and August

INDEX TO ADVERTISERS

	Page
Abbott Laboratories	12, 13
Airway Hotels, Inc.	53
Ames Company, Inc.	77
Barr X-ray Co., The	66
Beutlich, Inc.	61
Borden's	26
Burroughs Wellcome & Co., Inc.	10
Ciba Pharmaceuticals	39
Coca Cola Company, The	4
Davies, Rose & Company, Ltd.	70
Econo Lease of Milwaukee	40
Endo Laboratories	67
Glenbrook Laboratories	54
Hahn, Robert	60
Haug Drug Company	58
Hotel Schroeder	40
House of Bidwell, Inc.	66
Hurley X-ray Company	26
Keeley Institute, The	36
Lederle Laboratories	17, 28, 29
Lilly and Company, Eli	Front cover, 34
Medical Protective Company, The	18
Mid-Western Sport Togs	40
Milwaukee Sanitarium Foundation	26
Parke, Davis & Company	2, 3
Pfizer Laboratories	24, 25
Physicians' Exchange	71, 72, 73
Physicians Mutual Insurance Co.	66
Poythress, Wm. P. & Co., Inc.	22, 38
Professional Business Service	36
Rennebohm's	26
Robins Co., Inc., A. H.	6, 19, 20, 21
Roche Laboratories	Back cover
Rogers Memorial Hospital	18
Sacred Heart Sanitarium	76
St. Croixdale Sanitarium	4
Sanborn Company	37
Saunders Company, W. B.	9
Schering Corporation	33
Searle & Co., G. D.	35
Shorewood Sanitarium	66
Smith Kline & French Laboratories	27
Stark Co., The Paul E.	60
Tassette, Inc.	16
Time Insurance Company	36
Wallace Laboratories	11, 14, 15, 30, 31
Winthrop Laboratories	23, 32
Wisconsin Physicians Service	68

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the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

CONTENTS

Vol. 62, No. 5 MAY 1963

SCIENTIFIC ARTICLES

Cytology—A Community Service, by Philip G. Piper, M.D., Madison ---- 207
Present Status of Services for Cervical Cytology in Wisconsin, by Alfred S. Evans, M.D., Madison ---- 211
Cervical Cytology in Medical Practice Today, by Ben M. Peckham, M.D., Madison ---- 217
Trends in Three Cancer Sites, by A. L. Van Duser, M.D., M.P.H., Madison ---- 221
Clinicopathologic Conference, by Thomas R. Simon, M.D., Milwaukee ---- 223

SPECIAL ARTICLES

Cytological Screening for Uterine Cancer Through Physicians' Offices (abstract) ---- 210
Tampon Method for Mass Screening to Detect Carcinoma of Cervix Uteri (abstract) ---- 210
Appendicitis and Pregnancy (abstract) ---- 210
Experience with Cytology in Diagnosis of Uterine Carcinoma in a Private Hospital (abstract) ---- 220
Optimum Spacing of Repeat Follow-up Papanicolaou Smears (abstract) ---- 222
Pennsylvania Medical Society Acts on Cigarette Smoking ---- 228
Royal College of Physicians Reports on Smoking (abstract) ---- 228
An Industry Supplied the "Muscle" ---- 228
Policy Statement on Mammography by American Cancer Society ---- 228
Wisconsin Physicians and Cigarette Smoking, by R. J. Samp, M.D., Madison ---- 229
Comments on Treatment: Some Comments on the Pathogenesis of Agranulocytosis, by Anthony V. Pisciotta, M.D., Milwaukee ---- 230
Symptomatic Esophageal Hiatus Sliding Hernia: Clinical, Radiologic, and Endoscopic Study of One Hundred Cases (abstract) ---- 232
Measles Vaccine Information ---- 232
Picture Round-up of Conference on Health Fads and Fallacies ---- 236
Minutes of Council Meeting, Minneapolis, Minn., November 9–10, 1962 ---- 239

EDITORIALS

The New President: William J. Egan, M.D., Milwaukee ---- 233
Better Way ---- 234
Cytologic Revolution ---- 235
Deluxe Chiropractic ---- 235

REGULAR FEATURES

Letters of Interest ---- 6
News of Wisconsin Physicians ---- 21
Obituaries ---- 25
Society Records ---- 33
Facts about Wisconsin Physicians Service ---- 35
Medical Meetings—Postgraduate Courses ---- 49
Calendar of Meetings ---- 49
Physicians Exchange ---- 51
List of Officers of State and County Medical Societies and scheduled meetings of County Medical Societies ---- 54
Index to Advertisers ---- 56

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Journal
Established 1903
Annual Subscription ---- $6.00
Single Copy ---- 1.00
Previous Years' ---- 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 303 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

LETTERS OF INTEREST

TREATMENT OF THE MENOPAUSE

To WMJ:

A paper of mine entitled "The Roles of Estrogen and Progesterone in Breast and Genital Cancer," published in The Journal of The American Medical Association, continues to attract considerable attention. (Wilson, R.A. *182*:327–331 [Oct. 27] 1962). Requests for reprints continue to arrive; many from abroad and from behind the Iron Curtain. This paper concludes: "The evidence presented indicates that estrogen and progesterone are prophylactic to breast and genital cancer to an unknown degree. It is urgent that this process be intensively investigated. It would seem advisable to keep women endocrine-rich (estrogen-progesterone) and consequently, cancer-poor throughout their lives. A consequence of this would be the elimination of the menopause." In 2,387 years of patient-exposure to exogenous estrogen, no breast or genital cancers occurred although 18 was the expected incidence.

A related article entitled "The Fate of the Non-treated Postmenopausal Women, A Plea for the Maintenance of Adequate Estrogen from Puberty to the Grave" by Wilson, R. A., and Wilson, T. A., appears in the April issue of The Journal of the American Geriatrics Society. In this article it is shown that the menopausal woman is not normal; she suffers from a deficiency disease with serious sequelae and, without exception, needs treatment.

A third and key paper by Wilson, R. A., Hagstrom, H. T., Brevetti, R. E., and Wilson, T. A., entitled "Specific Procedures for the Elimination of the Menopause" will appear with an accompanying editorial in the May–June issue of the Western Journal of Surgery, Obstetrics and Gynecology. If the suggested appropriate methods are employed, a woman approaching the climacteric will not experience it, and the postmenopausal woman will be restored quickly to the premenopausal state. The degree of femininity (estrogenicity) of any woman whether young, perimenopausal, or postmenopausal, can be easily determined by an analysis of the percentages of superficial, intermediate and parabasal cells in the Papanicolau smear. This cytohormonal assay is the only practical guide in the management of the menopause.

Today the menopause is as obsolete as the bow and arrow. No woman need experience it or live with its cumulative effects. The re-education of almost every man, woman and physician in the civilized world is needed.

I feel certain that you will find this effort towards the final emancipation of women of interest.

Robert A. Wilson, M.D.
F.A.C.S., F.I.C.S., F.A.C.O.G.
90 Eighth Avenue
Brooklyn 15, New York

FILE ON MYCETISM DEATHS

To SMS:

The National Registry of Deaths from Mycetism maintains a file of deaths attributed to ingestion of wild mushrooms (1957 to date).

Physicians are requested to send notice of all such deaths (age, sex, date, locality) to the undersigned.

Robert W. Buck, M. D.
Secretary
Massachusetts Medical Society
22 The Fenway, Boston 15.

ORAL SURGEONS AWARD

To SMS:

The American Society of Oral Surgeons wishes to announce the presentation of a cash award at the Forty–Fifth Annual Meeting in Miami Beach, October 9–12, 1963. This award will be for superior, original, unpublished manuscripts concerning any phase of research related to oral surgery completed during the current year. All individuals interested in this competitive award should write:

American Society of Oral Surgeons
919 North Michigan Avenue
Chicago 11, Illinois

JOURNAL RECOGNITION

To SMS:

The library copy of your Journal is left on the shelves for use by the public and the students. I particularly would like to renew your Journal, because it is, in my opinion, one of the most representative. There are only three or four State Journals one has to read to keep up with local medical society thinking. Yours is one of them.

Harry Becker
Executive Secretary
Committee on Special Studies
The New York Academy of Medicine
New York

IMMUNIZATION INFORMATION FOR INTERNATIONAL TRAVEL

Copies of the booklet "Immunization Information for International Travel," revised June 1962, are available from the Superintendent of Documents, Government Printing Office, Washington 25, D.C. at 25¢ a copy.

NEWS OF WISCONSIN PHYSICIANS

Doctor Banyai Lectures

Dr. Andrew L. Banyai, Chicago, clinical professor of medicine, emeritus, Marquette University School of Medicine, gave a lecture at the VII International Congress on Diseases of the Chest held at New Delhi, India, Feb. 20–24, 1963. The subject of his presentation was "Homeostasis Versus Microbial Resistance."

A certificate of merit for scientific achievements was given to Doctor Banyai by the Japan Chapter of the American College of Chest Physicians at the tenth anniversary meeting of the Japan Chapter in Tokyo on Mar. 9, 1963.

Doctor Nicolaus to Green Bay

Dr. William H. Nicolaus, formerly of Madison, recently completed the residency program in anesthesiology at the University Hospitals, and has joined *Dr. Frederick D. Cook* and *Dr. James P. Mackey* in private practice at Green Bay.

Six Wisconsin Physicians Honored

Six Wisconsin physicians have been honored by the American College of Physicians. They were among those recently designated as fellows and associates of the ACP. Elected as fellows were: *Dr. Dean A. Emanuel,* Marshfield; and *Dr. Louis W. Sennett,* Milwaukee. Selected as associates were: *Drs. Gerson C. Bernhard, William L. Deardorff, Charles L. Junkerman,* and *John K. Olinger,* all of Milwaukee.

———

Physicians whose names appear in italic are members of the State Medical Society.

Dr. W. A. Sannes Observes 30th Year

On February 1 *Dr. W. A. Sannes* marked his 30th year as a practicing physician in Soldiers Grove.

New Physician at Arcadia

Dr. Hugo Schlagintweit of Goodsoil, Saskatchewan, Canada, has set up a medical practice in Arcadia. He occupies the third doctor unit in the Arcadia Medical Clinic. Doctor Schlagintweit, a native of Germany, attended medical colleges in Berlin and Heidelberg, Germany. Upon graduation in 1947, he practiced medicine at Heidelberg University Hospital and at other hospitals there. He came to Canada in 1951 where he practiced for 10 years at Goodsoil.

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Ref: Pena, E.F., Obst. & Gynec., *19*:794, 1962. Karnaky, K.J., Obst. & Gynec., *19*:688, 1962. Pena, E.F., Obst. & Gynec., *19*:684, 1962. Karnaky, K.J., Tri-State M.J. Sept., 1961. Burrus, S. Jr., Am. J. Obst. & Gynec. *80*:390, 1960. Karnaky, K.J., Tri-State M.J. Aug. 1960. Karnaky, K.J., Tri-State M.J., June, 1960. Liswood, R., Cur. Med. Dig., *26*:92, 1959. Schaefer, G., Clin. Obst. & Gynec., *2*:535, 1959. Liswood, R., Obst. & Gynec., *13*:539, 1959. Dickinson, R.L., JAMA, *128*:490 (June 16) 1945. Biskind, Mod. Med., *22*:128 (June 15) 1954.

To Head Victory Hospital Medical Staff

Dr. R. J. Mathwig of Stanley was elected president of the Victory Memorial hospital medical staff at a meeting of the group in December. He succeeds *Dr. J. W. Johnson.* Doctor Mathwig will also serve as chief of staff.

Dr. W. J. Tucker, Ashland, Honored

In ceremonies befitting the occasion, *Dr. William J. Tucker,* Ashland, was highly honored by the Veterans of Foreign Wars May 5 as Ashland's "Outstanding Citizen of the Year." Doctor Tucker, who has been chief surgeon at St. Joseph's Hospital for 42 years, was recognized for his compassion, kindness and sympathy as a physician, his humility and charity, and his religious conviction. In the words of Claude Cooper, the master of ceremonies, Doctor Tucker is "truly a man of noble character, a true and faithful servant of humanity," and in summing up the tribute he quoted the words of the poem, "Happiness will always be to him who serves humanity."

Many tributes were bestowed on Doctor Tucker, with entertainment and dinner included. A plaque was presented to him by Mr. Cooper.

Present to share in the receipt of the honor were his wife and son, Tom, of the Ashland High School faculty.

Doctor Tucker has been a member of the State Medical Society since 1922. He was one of the founders of the American Board of Abdominal Surgery, and has been author of numerous scientific papers on surgery.

Ashland Daily Press Photo by Peter R. Gander

Dr. William J. Tucker is shown on the right receiving a plaque as "Outstanding Citizen of the Year" from Claude Cooper, who made the presentation on behalf of the Chequamegon Memorial Post No. 690 of the Ashland Veterans of Foreign Wars, which had its annual awards dinner May 5.

New!

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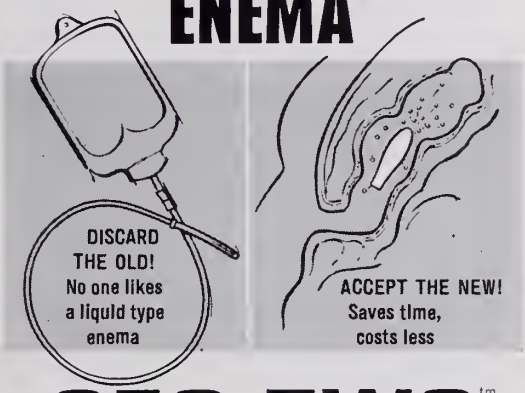

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OBITUARIES

Dr. W. G. Merrill, Ashland, died May 20, 1962, at the age of 87.

A native of Sparta, Wisconsin, Doctor Merrill was a 1906 graduate of Marquette University School of Medicine. After completion of his education, he located in Necedah and Wisconsin Rapids until his induction into military service in 1916. From 1936 to 1942, Doctor Merrill practiced in Nevada, returning to Wisconsin at that time. He practiced in Ashland for 17 years prior to his retirement in 1961.

He was a member of the Ashland–Bayfield–Iron County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Bertha; four sons, Lt. Will G., Jr., Fort Bliss, Texas; Llewellyn and Ralph, both of Little Marais, Minnesota, and Dean, Ashland; three daughters, Mrs. Bertha Nerad, Milwaukee, and Mrs. William Webner and Miss Sarah Louise, both of Ashland.

Dr. Malcolm F. Rogers, Milwaukee, a heart specialist, died May 22, 1962, at the age of 71.

A native of Milwaukee, Doctor Rogers was a 1918 graduate of Rush Medical College. He interned at Columbia Hospital, and completed his residency there in 1920 at which time he established his practice in that city.

Doctor Rogers was one of the first cardiologists in the United States. He had been a board member of the Wisconsin Heart Association for 20 years prior to his resignation a year ago. He had also been governor for Wisconsin of the American College of Cardiology. Doctor Rogers was Executive Director of Cardiac Services at Milwaukee Children's Hospital.

He was a member of the American Society for Study of Arteriosclerosis, the American Heart Society, the American College of Cardiology, the American Gerentological Society, The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Vlasta, and one daughter, Mrs. William T. Collings, Milwaukee.

Dr. William F. Janc, Chippewa Falls, died May 27, 1962, at the age of 55.

A native of Chicago, Doctor Janc was a 1935 graduate of Loyola Medical School, Chicago. Following internship, he was a clinical instructor at Mercy Hospital in Chicago until 1945, at which time, he established his practice in Chippewa Falls.

Doctor Janc was a member of the American Academy of General Practice, the Chippewa County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Etta; three sons, William F., Jr., and John, both of Chippewa Falls; Joseph, in military service; and one daughter, Mrs. K. A. Clements, of Chippewa Falls.

Dr. Adrian W. Davis, a prominent Madison physician, died August 27, 1962, at the age of 43.

Born in Kankakee, Illinois, Doctor Davis was a 1943 graduate of the University of Illinois College of Medicine. He interned at the United States Naval Hospital at Long Beach, California, and served his residency at the Naval Hospital in Albany, New York. After completion of his military service in 1947, he practiced for one year in Minnesota. In 1948, Doctor Davis began his practice in Madison, and entered clinic partnership in 1954.

He was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Asta; a son, Bruce; and a daughter, Rebel, all of Madison.

Dr. Charles L. Rumph, retired Milwaukee physician, died September 4, 1962, at the age of 86.

He was graduated from the University of Michigan Medical School in 1903, and after serving his internship, worked as a physician for a mining company prior to locating in South Milwaukee in 1911. Six years ago, Doctor Rumph retired to Florida after 40 years of medical practice in Wisconsin.

Doctor Rumph was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Bernice.

Dr. Albion A. Heidner, West Bend, a past president of the State Medical Society of Wisconsin died September 17, 1962, at the age of 73.

Born in Waukesha, Wisconsin, Doctor Heidner was a 1913 graduate of Rush Medical College. He interned and served his residency at Augustine Hospital, Chicago, from 1913 until 1915, coming to West Bend that year to begin medical practice in association with his father, the late Dr. Gustave Heidner. In 1930, Doctor Heidner was instrumental in incorporating the General Clinic at West Bend, where he practiced continuously until his death. He helped establish St. Joseph's Memorial Hospital, West Bend, and served as its first chief of staff.

Doctor Heidner, active in civic affairs, was treasurer of the West Bend School Board for 25 years, and was known as the father of basketball in that area. He was named "man of the year" in 1952 by the West Bend Kiwanis Club.

He was past president of the Washington County Medical Society, a member of the Council of the State Medical Society for 28 years, and served as president of the State Society in 1952. He was a member of the American Medical Association, Wisconsin chairman of the American Medical Education Foundation, and was active and past president of the Wisconsin Commission on the Improvement of Patient Care.

Surviving are his widow, Elsie; two sons, Richard C. of Libertyville, Illinois, and Andrew R. of Whitefish Bay, a sister, Miss Edith Heidner of West Bend, and a brother, Dr. Frederick Heidner of Milwaukee.

Dr. Simon O. Lund, 76, Cumberland died September 22, 1962.

A native of Montevideo, Minnesota, Doctor Lund was a graduate of St. Olaf College in 1907. After teaching for one year, he attended Gettysburg Theological Seminary in Gettysburg, Pennsylvania, for two years prior to entering Rush Medical College in Chicago. He received his M. D. degree in 1916, after which he interned at St. Barnabas Hospital, Minneapolis.

In 1921, Doctor Lund located in Cumberland, where he continued practice for over 40 years. He was active in civic affairs, serving 12 years on the school board, and was City Health Officer for a number of years. In 1929, Doctor Lund and his partner built the Cumberland Clinic. In 1946, the town honored him for 25 years of service to the community. Doctor Lund in recent years was semi-retired, although he kept office hours, was available for blood banks, and made daily hospital trips.

He was a member of the Barron–Washburn–Sawyer–Burnett County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors are his widow, Bertina; three sons, Dr. Robert, Cumberland; Dr. George, Minneapolis; and Simon, Los Angeles.

Dr. Andrew J. Loughnan, a retired Oconomowoc physician, died October 4, 1962, at the age of 89.

A native of Hastings, New York, Doctor Loughnan was a 1901 graduate of the University of Maryland at Baltimore. Following his internship at Elizabeth, New Jersey, he practiced in New York for two years before locating in Wisconsin. During World War I, Doctor Loughnan served in the Army Medical Corps. He had been a practicing physician in Oconomowoc for 43 years prior to his retirement two years ago.

In 1951, he became a member of the State Medical Society's 50-year club. Doctor Loughnan was a member and past president of the Waukesha County Medical Society, and a member of the American Medical Association.

He is survived by his widow, Rubie; and two nephews in New York State.

Dr. Lillie M. Morgan, 97, formerly of Albany died October 22, 1962, in Long Beach, California.

Doctor Morgan and her husband, Dr. S. J. Morgan, also deceased, practiced medicine in Albany for many years after graduating from General Medical College, Chicago, in 1892. She was a former village supervisor, and represented the village on the county Board. During World War I, she actively headed the Albany chapter of the Red Cross, and was active in many civic affairs. She retired to California many years prior to her death.

The only immediate survivor is her sister.

Dr. Alban Tessier, Milwaukee, died October 29, 1962, at the age of 59.

Originally from DePere, Wisconsin, Doctor Tessier attended St. Norbert College before receiving his medical degree from the University of Wisconsin Medical School in 1929. He served his internship at the University of Pennsylvania Graduate Hospital, and a three-year residency at Columbia Hospital, Milwaukee. After completion of his education, Doctor Tessier located in Milwaukee where he was continuously engaged in general practice until his retirement in 1962. In addition to his practice, he served as president of the Board of Health in the Milwaukee suburb of Shorewood.

Doctor Tessier was a member of the American Academy of General Practice, The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Ruth; two daughters, Mrs. Edward J. Bird and Patricia Ann; and one son, A. Thomas.

Dr. James M. Robbins, 72, a Milwaukee psychiatrist, died November 11, 1962.

Born in Ashland, Kentucky, Doctor Robbins received his medical education at Jefferson Medical College in Pennsylvania in 1917. He interned at Harrisburg General Hospital in Harrisburg, Pennsylvania, and served his residency at the Pennsylvania Hospital for Nervous and Mental Diseases until 1921.

Doctor Robbins started his practice in Wisconsin at St. Mary's Hill Hospital, Milwaukee, in 1923. From 1929 to 1938, he was with a Chicago hospital, and in 1938 he returned to St. Mary's Hill, where he was made Medical Director in 1942.

He was a diplomate of the National Board of Psychiatry and Neurology, and a fellow of the American Psychiatric Association. Doctor Robbins also was a member of the Central Neuropsychiatric Association, the Milwaukee Neuropsychiatric Society, The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

There are no survivors.

Dr. William H. McGuire, Janesville, died November 30, 1962, at the age of 78.

A native of Canada, Doctor McGuire was a 1908 graduate of Long Island Hospital Medical School. Following internship at St. John's Hospital, Long Island, New York, Norwegian and Swedish Hospitals in Brooklyn, he did additional studying at the Mayo Clinic, Rochester. He began practicing in Janesville in 1910; and served as district surgeon of the Northwestern Railroad since 1924.

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Doctor McGuire's 50 years of active practice were recognized by the State Medical Society in 1958, and his 50th year of practice in Janesville was marked in 1960.

He was a member of the American Academy of General Practice, past president of the Rock County Medical Society, a member of the State Medical Society of Wisconsin, and the American Medical Association.

Survivors are his widow, Julia, and a son, William H., Detroit.

Dr. Adeline Gauger, Wadsworth, Kansas, died December 13, 1962, at the age of 48.

A native of Milwaukee, Doctor Gauger was a graduate of the Marquette University School of Medicine. From 1942 to 1945, she was a physician for Boeing Aircraft at Seattle. She joined the staff at Pacific State Hospital, Spadra, California, in 1947, and came to Milwaukee in 1956, when she joined the staff at Wood Hospital.

Doctor Gauger was named assistant chief of physical medicine and rehabilitation at Wood in 1957, and served in that capacity until her transfer to Wadsworth in 1959.

She was a member of the Board of Directors of the Leavenworth Association of Mental Health, and belonged to the American Association of Women, and the Pan-American Medical Women's Association.

Surviving are four cousins.

Dr. William P. Wheeler, Oshkosh, died December 18, 1962, at the age of 84.

Born in Vermont, Doctor Wheeler was a 1907 graduate of the Wisconsin College of Physicians and Surgeons in Milwaukee. After serving his internship at St. Joseph's Hospital, Milwaukee, he located in Oshkosh. Doctor Wheeler was Health Commissioner and city physician in Oshkosh from 1937–1946. He was staff physician at Central State Hospital from 1951 to 1958, at which time he retired.

He was a past president of the Winnebago County Medical Society, and since 1957 a life member of the State Medical Society of Wisconsin and the American Medical Association.

Doctor Wheeler is survived by his widow and two children.

Dr. Arthur F. Rheineck, Oconomowoc, died December 25, 1962, at the age of 76.

A native of Fort Atkinson, he was a 1910 graduate of what is now Marquette University School of Medicine, and served his internship at Trinity Hospital. Doctor Rheineck began practice in Milwaukee at that time, and when he retired in 1959, had marked 50 years as a physician in that city.

He was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors are a son, John R., and a daughter, Mrs. Fred Grube, both of rural Oconomowoc.

Dr. John T. Morrison, Bethesda, Maryland, died December 26, 1962, at his home.

Doctor Morrison served as an instructor in physiology at the University of Wisconsin Medical School from 1924–1925. He received his medical degree in 1927, and served as chief resident at University Hospitals from 1921 to 1931, at which time he moved East.

In 1942, Doctor Morrison entered military service, and was on active duty, both in the United States and overseas until March of 1946. At that time, he resumed his position as assistant director of the rural hospital division of The Commonwealth Fund, New York City.

Doctor Morrison was a member of the State Medical Society of Wisconsin, and of Scabbard and Blade Honorary military society.

He is survived by his widow, Eleanor; a son and a daughter.

Dr. John H. Blekking, Sunny Ridge, died December 31, 1962, at the age of 100.

Born in the Town of Holland, Doctor Blekking graduated from what is now Marquette University School of Medicine in 1897. For three years after his graduation, Doctor Blekking practiced in Milwaukee, after which he returned to Sheboygan County where his practice covered a wide area. He then located for several years in Marathon County, before returning to Sheboygan Falls, where he was in practice until his retirement in 1933. On November 16, 1962, Doctor Blekking observed his 100th birthday.

He is survived by his widow, Dina; two sisters, Misses Emma and Ada Blekking of Cedar Grove; and three grandchildren.

Dr. Richard P. Sabin, a Madison psychiatrist, died January 5, 1963, at the age of 33.

Born in Rockford, Illinois, Doctor Sabin graduated from the University of Wisconsin Medical School in 1955. After his internship was completed in Portland, Oregon, in 1956, he returned to the University where his residency training in psychiatry was taken until 1961. Doctor Sabin served in the United States Air Force from 1957 to 1959. Upon completion of his medical education in 1961, Doctor Sabin entered private practice in Madison, and was a clinical instructor at the University of Wisconsin.

He was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Sabin is survived by his widow; a daughter, Lynn Ann; and a son, Craig, all of Madison.

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF MARCH 31, 1963

NEW MEMBERS

Paul G. Albrecht, 202 South "K" Street, Sparta.
Howard Albright, 1707 East North Avenue, Mequon.
Angelina S. Allen, 1552 University Avenue, Madison.
John B. Baker, 8700 West Wisconsin Avenue, Milwaukee.
Billy J. Bauman, 720 South Brooks Street, Madison 5.
William J. Beckfield, 310 Chestnut Street, Eau Claire.
J. M. B. Bloodworth, Jr., 2500 Overlook Terrace, Madison.
Wilbur F. Cant, 2 West Gorham Street, Madison 3.
Paul A. Capelli, 723—58th Street, Kenosha.
James A. Clemence, 10940 West Forest Home, Hales Corners.
Sterling Doubrava, Jr., 8700 West Wisconsin Avenue, Milwaukee.
Jerome J. Dowling, 6032 West Wells, Milwaukee.
Wilson S. Dunn, 219 North Bassett Street, Madison 3.
M. B. Fliegel, Box 3096, Madison.
R. P. Froeschle, 1300 University Avenue, Madison.
Adam Fueredi, Route 3, Merrill.
Konstantin Geocaris, 2710 Marshall Court, Madison 5.
Harry Gonlag, 413 Chestnut Street, Eau Claire.
James R. Hammes, 500 Walton Avenue, Racine.
Robert E. Handte, 336 Chute Street, Menasha.
Roger K. Harned, Cantwell-Peterson Clinic, Shawano.
J. B. Leith Hartman, 15350 West National Avenue, New Berlin.
Anthony A. Herrmann, 6515 Charles Street, Racine.
Donald D. Hillan, 92 East Division, Fond du Lac.
Paul C. Hodges, Jr., 103 West College Avenue, Appleton.
John K. Hoyer, 40 West Newton, Rice Lake.
Dorsey W. Hurst, 5106 Tokay Boulevard, Madison.
Julius H. Kelertas, 621 Davis Avenue, Eau Claire.
Eugene Krohn, 221 Main Street, Black River Falls.
Connie Lee, La Farge.
Bernard Levinson, 948 North 12th Street, Milwaukee.
Howard Levinson, 2964 South 29th Street, Milwaukee.
George L. Lucas, 1300 University Avenue, Madison.
Renate E. Madsen, 1317 Wingra Drive, Madison.
Harold E. Manhart, 1605 Monroe Street, Madison 5.
Wayne McFadden, 926 Milwaukee Avenue, South Milwaukee.
Nelson A. Moffat, Marshfield Clinic, Marshfield.
Gilbert F. Mueller, Jr., 1602 North Meade Street, Appleton.
James T. Murphy, 212 South 11th Street, La Crosse.
Thomas M. O'Connor, 7120 West Chambers Street, Milwaukee.
Karl A. Palmer, 103 First Avenue, West, Menomonie.
Charles E. Pechous, Jr., 1202—60th Street, Kenosha.
Ray D. Reed, 550 North Dewey Street, Eau Claire.
Ralph E. Reeds, Jr., Mondovi.
William R. Richards, 103 West College Avenue, Appleton.
George L. River, Marshfield Clinic, Marshfield.
Robert A. Rufflo, 5854 South Packard Avenue, Cudahy.
Milton Shapson, 161 West Wisconsin Avenue, Milwaukee.
Darrell R. Slette, 720 Irving Zuelke Building, Appleton.
Robert J. Sneed, 220 Seventh Avenue, West, Ashland.
Shigeo Sumida, 2405 Northwestern Avenue, Racine.
Peter Torbey, 508 South Mills Street, Madison.
C. Randolph Turner, 1212 West Wisconsin Avenue, Milwaukee.
Alejandro M. Vinluan, 5501 North 76th Street, Milwaukee.
James L. Windeck, 600 Bay Street, Chippewa Falls.
Robert C. Zuege, 2040 West Wisconsin Avenue, Milwaukee.

CHANGES OF ADDRESS

V. Balciunas, to 4050 Sheridan Road, Kenosha.
Robert C. Baldwin, to 1507 Doctors Court, Watertown.
Jay P. Bartlett, Milwaukee, to 2220 Moor Park Avenue, San Jose 28, Calif.
David J. Batzner, Waukesha, to 1226 North 8th Street, Sheboygan.
E. L. Belknap, Jr., to 2707 Marshall Court, Madison.
Janusz Belza, Menomonie, to 273 Walter Hays Drive, Palo Alto, Calif.
James F. Berg, to 324 East Wisconsin Avenue, Milwaukee.
William J. Blake, Elm Grove, to 1005 Russell Avenue, Salisbury, Md.
Celina D. Bobowski, to Winnebago State Hospital, Winnebago.
Bruce R. Bogost, to 242 East Chateau Place, Milwaukee 18.
Robert L. Bolton, Larsons AFB, Washington, to 10247 West National Avenue, Milwaukee.
Sam Bornstein, Milwaukee, to 6265 Sand Brach, Oconomowoc.
William McKinley Brown, Jr., Pasadena, to 3184 Olive Avenue, Altadena, Calif.
David Cleveland, Milwaukee, to 1322 Paseo De Maria, Palm Springs, Calif.
Leo J. Cogan, to 836 North 12th Street, Milwaukee 3.
Glenn Dall, Milwaukee, to 12900 West Wrayburn Street, Elm Grove.
Thomas B. Davis, to 802 Caroline, Neenah.
David L. Dean, Madison, to V. A. Hospital, 13000 Sayre Street, San Fernando, Calif.
James B. Dibble, Eau Claire, to Lutheran Medical Mission Hospital, Tanganyika, East Africa.
Ettore Di Miceli, Jr., Milwaukee, to 910 North Elm Grove Road, Elm Grove.
T. T. Draelos, Dugway Proving Grounds, Utah, to 1615 West 8th Street, Silver City, N. M.
Max F. Drozwski, to 1401A West Lincoln Avenue, Milwaukee 15.
C. E. Elson, Waukesha, to 4149 Brown Circle, Gurnee, Ill.
M. T. Erickson, to 5213 Hammersley Road, Madison.
A. S. Evans, to 437 Henry Mall, Madison.
L. L. Fifrick, Milwaukee, to 10425 West North Avenue, Wauwatosa.
Thomas P. Forrestal, to 3419 South 58th Street, Milwaukee.
T. C. Fox, Germantown, to 213 Fifth Avenue, Antigo.
R. G. Grantz, to 406 South East Avenue, Waukesha.
John J. Frederick, Milwaukee, to 5854 South Packard Avenue, Cudahy.
James W. Fulton, to 1429 South 70th Street, West Allis 14.
J. S. Garman, to 144 West Madison, Waterloo.
F. F. Gollin, to 6516 Elmwood Avenue, Middleton.
S. J. Graiewski, to 155 Sawyer Street, Oshkosh.
Robert Gregor, Oconomowoc, to Mental Health Clinic, Court House, Waukesha.
H. James Hamm, to 324 East Wisconsin Avenue, Milwaukee.
K. J. Harrington, to W154 N8083 Elm Lane, Menomonee Falls.

F. M. Hauch, to 722 Lawrence Street, Appleton.
G. T. Hegner, to 405 West Prospect, Appleton.
Orin A. Hermunstad, to 109 First Street, Stoughton.
Roger L. Hepperla, Fort Ord, California, to 4200 North 89th Street, Milwaukee.
Kurt Hoehne, Madison, to Manteno State Hospital, Manteno, Ill.
Thomas A. Hofbauer, Milwaukee, to N84 W15787 Menomonee Avenue, Menomonee Falls.
William C. Hoffmann, to 332 Jefferson, Hartford.
J. J. Homsey, to 5854 South Packard Avenue, Cudahy.
M. Rateb Homsi, Milwaukee, to Fairview Medical Center, 25701 Jay Road, Dearborn, Mich.
Donald T. Hughson, to 10425 West North Avenue, Milwaukee.
Carl A. Hultman, Milwaukee, to 909 Floweree, Helena, Mont.
J. J. Jacoby, Milwaukee, to 910 North Elm Grove Road, Elm Grove.
Darrell A. Jaques, Green Bay, to Fort Sam Houston, Houston, Tex.
Alfhild Jensen, La Crosse, to Puli Christian Hospital, Puli, Taiwan.
Hobart W. Johnson, to 740 North Plankinton Avenue, Milwaukee.
John R. Jones, Milwaukee, to 712 South 94th Avenue, Omaha 14, Neb.
Merritt L. Jones, to 400 Strollers Lane, Wausau.
Henry R. Karlin, to 6730 West Keefe Avenue, Milwaukee 16.
A. J. Kilian, to 7510 Portland Avenue, Milwaukee.
Morris Klein, to 4906 West Fond du Lac Avenue, Milwaukee.
Milton G. Klumb, to 2249 North 48th Street, Milwaukee 8.
Stephan A. Konz, to 689 West Foster Street, Appleton.
C. L. Lacke, to 5202 Coney Weston Place, Madison 11.
J. P. La Flare, to 986 Ninth Street, Green Bay.
Jamil T. Laham, Ripon, to Three Lakes Clinic, Three Lakes.
Thomas A. Leonard, Jr., Madison, to R.F.D #1, Middleton.
J. A. Leschke, to 155 Sawyer Street, Oshkosh.
William C. Lewis, to 1300 University Avenue, Madison 6.
William J. Little, to 312 Seventh Street, Racine.
T. M. Loescher, to 412 East Longview Avenue, Appleton.
Pearl M. Loveland, to 5206 Flad Avenue, Madison.
Joseph Lubitz, West Allis, to 5900 South Lake Drive, Milwaukee.
R. L. MacCornack, Sr., Phoenix, Ariz., to 1714 Lincoln Street, Whitehall.
James P. Mackey, to 1601 McArthur Street, Green Bay.
C. G. Maloney, Ft. Atkinson, to 2575 Eighth Street, National City, Calif.
Dale H. Mann, Milwaukee, to 17258 North Avenue, Brookfield.
Stanton A. Marks, to 7635 West Oklahoma, Milwaukee 19.
V. F. Marshall, to 504 East North Street, Appleton.
William E. Mateicka, Menomonee Falls, to 12605 Gremoor Drive, Elm Grove.
H. J. McGinnis, Union Grove, to Grand Army Hospital, King.
Desmond P. McNelis, Milwaukee, to Seton Psychiatric Institute, 6420 Riesterstown Road, Baltimore 15, Md.
Theodore F. Meves, to 8828 North Port Washington Road, Milwaukee.
William R. Mills, to 6831 West Villard Avenue, Milwaukee.
Walter L. Modaff, Wauwatosa, to 6726 Colby Avenue, Des Moines, Ia.
James J. Nora, Beloit, to 1300 University Avenue, Madison.
P. E. Oberbreckling, to 2304 East Lake Bluff Boulevard, Milwaukee.
Andrew J. Owens, to 4441 West Fond du Lac Avenue, Milwaukee 16.
J. W. Pavelsek, to 122½ East Cook Street, Portage.
Joseph M. Pawlowski, to 2900 West Oklahoma Avenue, Milwaukee.
B. M. Peckham, to 1300 University Avenue, Madison 6.
Arche Pequet, to 10425 West North Avenue, Milwaukee.
E. B. Pfefferkorn, to 533 Mt. Vernon Street, Oshkosh.
W. S. Phillips, to 6167 North Berkeley Boulevard, Milwaukee.
W. H. Pinkus, to 312 Seventh Street, Racine.
Ralph T. Rank, to 324 East Wisconsin Avenue, Milwaukee 2.
Allen Robin, to 2040 West Wisconsin Avenue, Milwaukee 3.
Alfred F. Rodenbeck, to 1210 East Oklahoma Avenue, Milwaukee.
Sion Clay Rogers, to 2500 Overlook Terrace, Madison.
K. M. Sachtjen, to 5001 Bayfield Terrace, Madison.
F. M. Schammel, to 109 Forest Street, Stoughton.
John Schelbe, to 2266 North Prospect Avenue, Milwaukee.
Johanna E. Schlichting, to 2028 North Seventh Street, Sheboygan.
Howard F. Schloemer, to N89 W15791 Main Street, Menomonee Falls.
Claude W. Schmidt, to 725 American Avenue, Waukesha.
E. J. Schmidt, Milwaukee, to 2500 North 108th Street, Wauwatosa.
James R. Schmidt, to N89 W16800 Appleton Avenue, Menomonee Falls.
L. J. Seward, to 147 North State Street, Berlin.
James B. Shack, Highland, to 924 East Fourth Mile Road, Racine.
Robert A. Sievert, La Crosse, to 181 Madison Avenue, River Edge, N. J.
P. H. Smith, to 3041 North Sherman, Milwaukee.
Reuben J. Snartemo, to 3510 West Burnham Street, Milwaukee 15.
Francis J. Stadler, Jr., to 1227 East Wornimont, Milwaukee.
C. L. Steidinger, to 1030 North Water Street, Platteville.
Frank G. Stergiades, to 945 North 12th Street, Milwaukee.
Leo Stockland, to 7635 West Oklahoma, Milwaukee 19.
James K. Trumbo, to 607 Third Street, Wausau.
G. B. Tybring, to 110 East Main Street, Madison 3.
V. N. Vitulli, Milwaukee, to 5854 South Packard Avenue, Cudahy.
Thorn L. Vogel, to City Health Commissioner, Health Department, City Hall, Janesville.
William A. Wagner, to 421 Jefferson Street, Oshkosh.
H. M. Waldren, Jr., to 3183 South 76th Street, Milwaukee.
Thomas W. Weis, to 319 West College Avenue, Waukesha.
Lewis J. Weller, New Richmond, to 610 Van Buren, Corvallis, Ore.
Edwin C. Welsh, to 12130 Meadow Court, Milwaukee 10.

Facts about

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There are approximately 35,000 Federal employees and dependents in Wisconsin who are protected by Blue Shield.

To prevent possible duplication of benefit payments under this program, PHYSICIANS OUTSIDE MILWAUKEE COUNTY are requested to send all Federal employee claims to Wisconsin Physicians Service.

Important information for Medical Assistants:

When filing a claim for services performed for any person covered by the Federal employee Blue Shield plan, prepare a WPS CLAIM FORM and send it to Wisconsin Physicians Service in Madison.

WPS will also promptly pay claims for Federal employees and dependents that are submitted on claim forms of other Blue plans.

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REPORTING OF NARCOTIC DRUG LOSSES

Because some Wisconsin physicians who have suffered a loss of narcotic drugs by theft or other manner have failed to notify the Bureau of Narcotics as required by regulations, the Bureau has issued the following procedure that is required by Regulations No. 5:

"Where narcotic drugs are lost by theft, or otherwise lost or destroyed in transit, the consignee shall immediately upon ascertainment of the occurrence file with the narcotic District Supervisor, a signed statement of the facts, including a list of the narcotics stolen, lost or destroyed, and documentary evidence that the local authorities were notified. A copy of the statement shall be retained and filed with the other narcotic records of the consignee."

In Wisconsin, reports should be sent to the District Supervisor, Federal Bureau of Narcotics, 817 New Post Office Building, Chicago 7, Ill.

MEDICARE BENEFITS EXTENDED TO DEPENDENTS OF NATO FORCES

The Office for Dependents' Medical Care has provided the following notice to local Medicare offices throughout the country:

"On and after 1 July 1963 the accompanying dependents of active duty military personnel, who are members of the land, sea and air forces of North Atlantic Treaty Organization countries stationed or passing through this country, will be entitled to the same care under the Medicare Program as those dependents of members of the uniformed services. The standard Identification Form DD Form 1173 will be furnished to those dependents and all contractual provisions and criteria as to scope of care and eligibility will be the same as for dependents of members of our uniformed services."

Doctors who are called upon for services to the above described dependents of servicemen of NATO countries are asked to submit claims just as they do for dependents of U. S. servicemen. Doctors are cautioned to make certain that FULL INFORMATION IS SECURED ON THE PATIENT'S FIRST VISIT because of the increased likelihood that these people may be transients and not available for later contacts.

SOCIETY RECORDS *Continued*

William P. Wendt, Milwaukee to 1905 Hollyhock Lane, Elm Grove.
Sidney Wetzler, to 1028 East Juneau, Milwaukee.
George E. Whalen, Jr., to 18045 Burleigh Road, Brookfield.
W. H. Williamson, to 500 Walton Avenue, Racine.
Carlton Wirthwein, to 7635 West Bluemound Road, Milwaukee.

REMOVED FROM MEMBERSHIP

John R. Allen, Dane County, resigned.
Charles E. Andre, Milwaukee county, transferred to Ohio.
Michael Ballard, Milwaukee county, transferred to Maine.
Edward A. Brucker, Jr., Dane county, transferred to Arizona.
David J. Buran, Winnebago county, resigned.
J. C. Devine, Milwaukee county, transferred to Oklahoma.
E. P. Engels, Barron–Sawyer–Washburn–Burnett county, transferred to Minnesota.
Robert E. Fitzgerald, Milwaukee county, transferred to Illinois.
John H. Flinn, Dane county, removed per county secretary.
R. L. Fodor, Milwaukee county, transferred to Ohio.
Frank J. Glassy, Wood county, transferred to California.
Edwin A. Heipp, Milwaukee county, resigned.
D. E. Howland, Dane county, transferred to Arizona.
W. A. Krehl, Milwaukee county, transferred to Iowa.
Elwood W. Kreutzer, Dane county, transferred to California.
F. A. Luckay, Milwaukee county, transferred to Texas.
Donald L. Minter, Rock county, resigned.
Nola M. Moore, Dane county, transferred to Washington.
J. V. Osborne, Wood county, transferred to Indiana.
Parviz Shams-Avari, Dane county, transferred to Michigan.
Thaddeus D. Smith, Winnebago county, resigned.
Theodore C. Smith, Dane county, removed per county secretary.
Roy W. Zimmer, Jr., Dane county, transferred to Washington.

DEATHS

Elizabeth Toussaint, 12–12–62, non-member.
Adeline Gauger, 12–13–62, non-member.
William P. Wheeler, 12–17–62, Winnebago county, Oshkosh.
A. F. Rheineck, 12–28–62, Milwaukee county, Oconomowoc.
Alexius Banach, 1–14–63, non-member.
Richard P. Sabin, 1–14–63, Dane county, Madison.
George A. Steele, 1–14–63, Winnebago county, Oshkosh.
Rolla U. Cairns, 1–17–63, Pierce–St. Croix county, River Falls.
John A. Cox, 2–1–63, Milwaukee county, Milwaukee.
Sidney B. Russell, 2–7–63, Eau Claire–Dunn–Pepin counties, Eau Claire.
Edgar F. Andre, 2–12–63, Kenosha county, Kenosha.
W. J. Meek, Ph.D., 2–15–63, honorary member.
Robert S. Irwin, 2–28–63, Milwaukee county, Milwaukee.

CALENDAR OF MEETINGS

1963 **Wisconsin**

June 13–15: Postgraduate course on Psychoanalysis and Current Biological Thought, University of Wisconsin Center building, Madison.

June 15: Annual meeting and scientific session of the Wisconsin Heart Association, Northwestern Mutual Life Insurance Co., Milwaukee.

Oct. 17: Lillie memorial lecture honoring Milwaukee Hospital centennial, by Dr. S. Leon Israel, professor of obstetrics and gynecology, University of Pennsylvania Graduate School, Milwaukee.

Oct. 20–23: Annual District VI meeting of American College of Obstetricians and Gynecologists, Milwaukee.

Nov. 21: Eberbach Memorial lecture honoring Milwaukee Hospital centennial, by Dr. Carl E. Badgley, professor of orthopedic surgery, University of Michigan School of Medicine, Milwaukee.

1963 **Out-of-State**

June 13–17: Annual meeting of the American College of Chest Physicians, Atlantic City, N. J.

June 15–16: Second symposium on Anxiety and Depression, sponsored by the Academy of Psychosomatic Medicine, Atlantic City, N. J.

June 16–20: 112th Annual Meeting of the American Medical Association, Atlantic City, N. J.

June 24–28: Postgraduate course on Psychiatry for the Internist, University of Colorado Medical Center, Denver.

June 30–July 1–5: Postgraduate course on Ophthalmology, University of Colorado Medical Center, Colorado Springs.

July 8–10: Postgraduate course on Obstetrics and Gynecology, University of Colorado Medical Center, Denver.

July 12–13: Rocky Mountain Cancer Conference, Brown Palace Hotel, Denver, Colo.

July 15–19: Second International Conference on Congenital Malformations sponsored by The National Foundation–March of Dimes, Americana Hotel, New York City.

July 18–20: Postgraduate course on Dermatology, University of Colorado Medical Center, Denver.

Aug. 5–9: Postgraduate course on Pediatrics, University of Colorado Medical Center, Estes Park.

Aug. 19–23: Medical Audiology Workshop, University of Colorado Medical Center, Denver.

Aug. 26: Annual meeting of American Academy of Physical Medicine and Rehabilitation, Sheraton–Dallas Hotel, Dallas, Tex.

Sept. 16–20: Pulmonary Disease Seminar, University of Colorado Medical Center, Fitzsimons General Hospital, Denver.

Sept. 22–28: XVII World Medical Assembly, Mexico City.

Sept. 25–26: National Congress on Occupational Health, sponsored by the AMA's Council on OH, San Francisco.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, sponsored by the Council on International Affairs of the American College of Chest Physicians, Mexico City.

Oct. 13–19: XVIIth World Medical Assembly (originally scheduled in Mexico City Sept. 22–28), Commodore Hotel, New York City.

Oct. 16–19: Conference on Obstetric, Gynecologic and Neonatal Nursing, sponsored by District VI, American College of Obstetricians and Gynecologists, Chicago.

Oct. 21–22: 1963 Scientific Session of American Cancer Society—A conference on "Unusual Forms and Aspects of Cancer in Man", Biltmore Hotel, New York City.

Oct. 24–26: Course in Postgraduate Gastroenterology, American College of Gastroenterology, Washington, D. C.

Oct. 23–25: Chiefs-of-staff Conference, University of Colorado Medical Center, Denver.

Nov. 5–13: Ninth Congress of the Pan–Pacific Surgical Association, Honolulu, Hawaii.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Nov. 13–Dec. 10: First Pan–Pacific Mobile Educational Lecture Seminar, New Zealand, Australia, Thailand, the Philippines, Hong Kong and Japan.

Nov. 18–21: Annual meeting of the Southern Medical Association, New Orleans, La.

Wisconsin Heart Association

The president of the American Heart Association will highlight a list of nationally prominent physicians who will present papers at the 15th annual meeting and scientific sessions of the WHA. The one-day meeting will be held in Milwaukee, Saturday, June 15, in the Northwestern Mutual Life Insurance company, 720 E. Wisconsin Ave.

Dr. James V. Warren, Columbus, O., professor and chairman, department of medicine, Ohio State University, and president of AHA, will discuss Cardiac Output and Blood Pressure—Mechanisms of Control at the scientific sessions.

Other physicians presenting papers include: Dr. Alfred P. Fishman, director, cardiorespiratory laboratory, Columbia University, New York; Dr. Herbert L. Abrams, professor of radiology, Stanford Medical Center, Palo Alto, Calif.; Dr. Arthur Selzer, professor of medicine, Stanford University, San Francisco; and Dr. E. E. Eddleman, Jr., associate chief of staff for research and education, Veterans Administration hospital, Birmingham, Ala.

Doctors Warren and Abrams will present the Malcolm F. Rogers lecture at the meeting.

A session for registered nurses will include as guest speakers: Miss Capitola Mattingly, R.N., director, graduate studies in nursing, Duke University, Durham, N. C.; and Hans Mauksch, Ph.D., dean of liberal studies, Illinois Institute of Technology, Chicago. This program will feature Psychological and Social Implications of Heart Disease Nursing.

Wisconsin State Medical Assistants Society

The ninth annual convention of the WSMAS will have as its theme: Satellite to Aesculapius. The two-day meeting will be held June 8 and 9 at the Fountain Park Motor Hotel in Sheboygan.

Mrs. June S. Gillette, president of the Society, will welcome the participants. The Honorable Emil Muuss, mayor of the City of Sheboygan, and Dr. Edward Houfek, advisor from Ozaukee–Sheboygan County, will respond.

The Saturday morning session speakers will be: Mrs. Georgette Johnson, Sheboygan, whose subject will be Effective Letter Writing; Mr. J. E. Te-Poorten, Manitowoc, The Challenge of Change; and Dr. John Hirschboeck, Milwaukee, The Medical Assistants Role in Medical Care.

Miss Edith Murphy, president-elect of the Society, will preside at the noon luncheon. Luncheon speaker will be Mrs. Lorraine Genesen, Chicago Heights, Ill., who will discuss Your Smile Isn't Showing. A medical quartet from Sheboygan will also entertain.

Dr. Herman Heise, Milwaukee, will lead off the afternoon session with a discussion of The Case of the Driving Drinker. Other speakers: Dr. W. W. Bauer, Chicago, Ill., Patients Are People; and Mr. Donald Ward, Milwaukee, Opening the Door.

A social hour from 6 until 7 will precede the evening banquet. Mr. Cliff Hutchinson, Madison, will be master of ceremonies. The Mad Hatters barbershop quartet of Sheboygan will entertain as well as Dr. Robert Pavlic, Brookfield, whose topic will be ESP—Mind or Matter? Miss Alice Budny, Milwaukee, will bring greetings from the American Association of Medical Assistants, of which she is president.

The annual business meeting will start at 9:30 Sunday morning. Election of officers will be a major item on the agenda. A luncheon at noon will be followed by installation of officers. Dr. Daniel Dorchester, Sturgeon Bay, will bring greetings as advisor for both WSMAS and AAMA. Installing officer will be Miss Budny.

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An executive committee meeting will be held at 3 p.m.

Rocky Mountain Cancer Conference

Dr. Edward R. Annis, president-elect of the American Medical Association, will be one of the principal speakers at the 17th annual Rocky Mountain Cancer Conference, July 12–13, at the Brown Palace Hotel in Denver, Colo.

Speakers on the two-day scientific program include: Doctors James C. Doyle (Ob–Gyn), Beverly Hills; Edward A. Gall (pathology), Cincinnati; Olof H. Pearson, (laboratory medicine), Western Reserve; Henry L. Jaffee (radiation therapy and nuclear medicine), Cedars of Lebanon Hospital; Howard R. Mahorner (surgeon), New Orleans; Murray M. Copeland (oncology), University of Texas, Houston.

Application has been made for AAGP accreditation. Further information: Rocky Mountain Cancer Conference, 1809 East 18th Avenue, Denver 18, Colo.

Course in Postgraduate Gastroenterology

The annual course in postgraduate gastroenterology of the American College of Gastroenterology will be given at the Shoreham Hotel in Washington, D. C., Oct. 24, 25, and 26.

The faculty for the course will be drawn from the medical schools in and around Washington. The subject matter to be covered, from the medical as well as the surgical viewpoint, will be essentially, the diagnosis and treatment of gastrointestinal diseases and comprehensive discussions of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gallbladder, colon and rectum. A clinical session will be held at one of the hospitals in Washington in addition to the several individual papers to be presented.

For further information and enrollment, write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

Annual Public Health Meeting, Madison

Two well known speakers and 12 special interest sessions are on the program for the 1963 meeting of the Wisconsin Public Health Association, to be held on June 18–19 at the Wisconsin Center Building, Madison. Stephen Kegeles, Ph.D., will open the session on Tuesday morning with the subject: "The Image of Public Health." A panel representing the viewpoints of several professions will then discuss the subject matter of Doctor Kegeles' talk. On Wednesday, LeRoy Burney, M.D., will address the general session discussing the work of the National Commission on Community Health Services. Doctor Burney is a former Surgeon General of the United States and is now a member of the NCCHS, Pittsburgh. Doctor Kegeles is a research associate and lecturer at the University of Michigan School of Public Health. Between the two general sessions will be an even dozen special interest sessions.

Classified Advertisements

Advertisements in this section are accepted in two categories: PHYSICIANS' EXCHANGE and COMMERCIAL.

RATES: 10¢ per word, with a minimum charge of $4.00 per ad. Additional insertions of same ad at one-half price each, maximum time one year. Display: $10.00 per column inch.

DEADLINE: Copy must be received by the 15th of the month preceding month of issue. Send copy to: Wisconsin Medical Journal, Box 1109, Madison 1, Wis.; or phone ALpine 6–3101.

PHYSICIANS' EXCHANGE: This section is limited to physicians and others desiring physician placement, sale of medical practice or equipment of a physician, sale or lease of medical buildings, etc. Advertisements from individual members of the State Medical Society of Wisconsin are accepted without charge. Widows of deceased member physicians are allowed to advertise without charge. The rates quoted above apply to ads placed by clinics and others. There is no additional charge for ads with Dept. numbers. For these ads, address replies to: Dept. ___, % Wisconsin Medical Journal, Box 1109, Madison 1, Wis. Advertisers using Dept. numbers forbid the disclosure of their identity. All inquiries are forwarded to them immediately.

COMMERCIAL: Advertisements are accepted at the above rates from individuals, firms, organizations, etc., who are reputable, have a good credit rating and advertise products or services of ethical standards. The Journal reserves the right to reject any advertising. Advertisements from member physicians are also accepted at the above rates.

PHYSICIANS' EXCHANGE

WANTED: MEDICAL TECHNOLOGIST. Immediate opening for a second ASCP or eligible for registration. Salary commensurate with qualifications. Relatively new hospital. Bed capacity 71. Well equipped laboratory. Medical staff of 13. U. S. Highway 14—35 miles S. E. La Crosse, Wis. Write Administrator, Vernon Memorial Hospital, Viroqua, Wis. 5

FOR SALE: UNOPPOSED small town general practice, southwestern Wisconsin. Modern, well equipped, air conditioned building, excellent open staff hospital nearby. Annual gross over $50,000. Contact Dept. 999 in care of the Journal. m8tfn

WANTED: Certified or qualified specialist in—

1. Psychiatry
2. Neurology
3. Plastic Surgeon
4. Pathology
5. Anesthesiology
6. Ophthalmology
7. Proctology

also Registered Pharmacist and EEG Technician to join 28-man, all-specialist group. Contact Harold E. Scherer or Robert G. Zach, M.D., The Monroe Clinic, Monroe, Wis. 4tfn

FOR SALE: Established EENT practice, over 40 years in the heart of Milwaukee. Excellent referrals; will introduce; retiring. Contact Dept. 24 care of the Journal. m12tfn

OFFICE SPACE for two or three physicians, OB or two surgeons. To rent or to sell. Pharmacy in same building. Contact Dept. 33 in care of the Journal. m3tfn

WANTED: GENERAL PRACTITIONER as associate. Immediately available opportunity to practice in well established group of two. Replacement for sudden loss of partner. Eventual partnership. 126 E. Main Street, Madison. AL 6-3171. m9tfn

PEDIATRICIAN desires association with a group or another pediatrician. Contact Dept. 47 in care of the Journal. m4–5

WANTED IMMEDIATELY: Young general surgeon (Board eligible or Board certified) to practice with 5-man group which includes 4 GPs and a radiologist, in new 6,000 sq. ft. clinic building, in college town of approximately 5,000 located 30 miles from Twin Cities. Excellent starting salary with early partnership.

ALSO WANTED: Young GP to associate with above group. Excellent starting salary with early partnership. Contact Edward A. Jenkins, Manager, River Falls Medical Clinic, Ltd., River Falls, Wis. 4tfn

WANTED: GENERAL PRACTITIONER as a replacement in town of 1,275 in southern Wisconsin. Gross receipts $42,000 in 1961, over $24,000 first 6 months 1962. Unopposed, good schools, churches, roads, fishing. Nearby accredited 200 bed hospital. Leaving for residency. Contact: D. L. Minter, M.D., Clinton, Wis. m9tfn

WANTED: PSYCHIATRISTS or young doctors, interested in psychiatry to work at Mendota State Hospital. These positions are permanent and under Civil Service; salary depends upon previous experience and training. Housing available on grounds. Contact W. J. Urben, M.D., Superintendent, Madison 4, Wis. g10tfn

FOR SALE: Two level home and office on bank of river; 45-acre estate near town of 6,000, 70 miles north of Madison. Hospital, good schools, several churches. Man with surgical training desirable. Purchase may be made by land contract. Might consider a locum tenens with potential permanent arrangement. A highly flexible opportunity for the right person. Contact Dept. 23 in care of the Journal. m12tfn

WANTED: INTERNIST, Board certified, to join two established surgeons. Excellent office facilities. Opposite 300-bed hospital—200-bed added expansion in progress. Town of 15,000. Central Wisconsin. Guaranteed salary. Percentage and partnership early prospects. Contact Paul F. Doege Medical Center, 512 St. Joseph Ave., Marshfield, Wis. m3tfm

WANTED: GENERAL PRACTITIONER for association with two-man group located near Madison. Excellent hospital and recreational facilities. Salary open to start with partnership opportunity at end of one year. New building with excellent equipment and personnel. Contact Dept. 52 in care of the Journal. m4tfn

PHYSICIANS, with or without pediatric training, needed in maternal and child health program at salaries ranging from $9,960.00 to $13,200.00. Five-day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, Milwaukee Health Department, Municipal Building, Milwaukee 2, Wis. g8tfn

GENERAL PRACTICE FOR SALE. Physician desiring own x-ray equipment may purchase radiographic, fluoroscopic and therapy equipment. Seven-room office on main corner in southern Wisconsin city of 35,000 occupied for over 40 years. Wish to retire. Reasonable price. Contact Dept. 19 in care of the Journal. m11tfn

PARTNER IN GENERAL PRACTICE WANTED in Green Lake county, town of 5,000. Fifty-bed private hospital. Five grade schools and one high school. No predominant nationalities. Various churches. Main occupations are leather, fur and metal. Contact Dept. 20 in care of the Journal. m11tfn

WANTED: PHYSICIAN with military service fulfilled to associate with a general surgeon also in general practice in northeastern Wisconsin in a city of 75,000. Excellent salary leading to early partnership. This is an A-1 financial opportunity. An early interview is appreciated. Contact Dept. 43 in care of the Journal. m4tfn

URGENTLY NEEDED: Associate going for residency—another man urgently needed. Twelve miles east of Fond du Lac, Catholic rural area. Start at $1,300 or more monthly. No investment. Available June. Contact Jos. F. Miller, M.D., Mt. Calvary, Wis. m4tfn

WANTED: INTERNIST, Board certified or eligible for association with young internist in southeastern Wisconsin city of 90,000. Contact Dept. 980 in care of the Journal. m4tfn

FOR SALE: IN WISCONSIN. General practice, well established, same location 40 years, fully equipped 7-room office. Will take any reasonable offer and finance as you wish. Poor health forces retirement. Contact Dept. 912 in care of the Journal. m4tfn

WANTED: PHYSICIAN to share a clinic which is now occupied by an M.D. and a D.D.S., located in a prosperous southeastern Wisconsin industrial and farming community where the need for another physician is very great. Contact Dept. 827 in care of the Journal. 4tfn

FOR SALE: PEDIATRICS PRACTICE in suburb of large Wisconsin city; will introduce; buyer assume two-year lease; open hospital staff; physician leaving Sept. 1, 1962, for academic post. Contact Dept. 985 in care of the Journal. m5tfn

ST. PAUL: General practitioner needed to fill third position with two 39-year-old AAGP members. Own beautiful, air-conditioned office building. Salary related to experience and early partnership desired. Contact Dept. 49 in care of the Journal. 4–6

WANTED: GENERAL PRACTITIONER to become associated with small group in central Wisconsin, preferably one who has had some practical experience, and has a special interest in obstetrics; also willing to only assist in surgery. Contact Dept. 969 in care of the Journal. m2tfn

ADDITIONAL OBSTETRICIAN–GYNECOLOGIST for northern Minnesota general practice and specialty group. Early partnership. Contact A. M. Antonow, M.D., East Range Clinic, Virginia, Minn. 4–6

OFFICE SPACE in medical clinic, 2218 North Third Street, Milwaukee, Wis.; Co. 4–2800. m3tfn

WANTED: GENERAL PRACTITIONER to replace physician who left for residency training. Fully equipped office available immediately. Town of 2,100 offers good hospital, skiing, hunting, golf, fishing and many other recreational advantages along the Chippewa River near its junction with the Mississippi. Financial remuneration should be excellent from the start. Contact Dept. 7 in care of the Journal. m9tfn

WANTED: GENERAL PRACTITIONER for associate with two other general practitioners in community of 2,400 with trade area of 7,000 in Green county. No investment required. Excellent clinical and diagnostic facilities. 200 bed hospital 15 miles. Good educational facilities. Convenient communications to recreational areas. Contact M. W. Stuessy, M.D., Brodhead. m3tfn

GENERAL PRACTICE available immediately in Milwaukee, Wis. (southeast side). Established 35 years, busy active practice, excellent location, beautiful ground floor clinic building, air-conditioned. Contact Dept. 41 in care of the Journal. m4tfn

GENERAL PRACTICE for sale in southeastern Wisconsin. Active practice of 13 years standing. For price of equipment and real estate. Air-conditioned first floor office, 1800 sq. ft. Supplementary rental income from three dental offices upstairs. City 3,500, drawing area 6,000. Open staff hospitals nearby. In fishing, hunting area. One hour away from State's largest cities for shopping, cultural activities. Contact Dept. 42 in care of the Journal. m4tfn

WANTED: OB-GYN physician and a general practitioner with some general surgical training to associate with another physician. Beautiful, large, new, well-equipped office. Parking lot. Air-conditioned. Starting salary $1,000. Partnership. City 10,000; drawing area 20,000. North Central Wisconsin. Contract Dept. 46 in care of the Journal. m4tfn

GOOD LOCATION AVAILABLE for general practitioner. Nothing to buy. Will assist and refer all general practice cases. Contact C. A. Sholtes, M.D., Richland Center, Wis., Midway 7–2592 or 7–2544. m9tfn

FOR SALE: GENERAL PRACTICE, well trained and active, in new fully equipped clinic building. Present physician leaving for residency. Personnel well trained and efficient. Rural village 38 miles northeast of Madison. New school, swimming pool, good housing available. Subsidy can be arranged through village. Contact Joseph G. Brown, M. D., Cambria, Wisconsin. m6tfn

FOR SALE: GENERAL PRACTICE in Chippewa Falls, Wis.; well established, same location for 17 years, fully equipped 5½-room office. Will take any reasonable offer and finance as you wish. Office help available. Practice available because of recent death of William F. Janc, M.D. Contact Mrs. William F. Janc, 300 Macomber Street, Chippewa Falls, Wis. m7tfn

MEDICAL SUITE: Thiensville–Mequon Medical Center Building, Thiensville, Wisconsin. Two doctors' offices, four examining rooms, lead lined x-ray room, laboratory, general office and waiting room. Heating and air conditioning furnished by owner. Available Nov. 1, 1963. Phone Chestnut 2–1080 or Chestnut 2–2344. E. C. Neidner, 231 South Main Street, Thiensville, Wisconsin. 5tfn

WANTED: GENERAL PRACTITIONER as associate in a four-man group with adequate clinical facilities. Offer open for two or three year locum tenens or for permanent association in the group. Town of 4,000, well-equipped 80-bed hospital, in west central Wisconsin. Contact Dept. 10 in care of the Journal. m9tfn

EENT SPECIALIST NEEDED for Eau Claire and vicinity, population 60,000. Could take over 20-year practice of deceased physician. Very advantageous opportunity. Contact Mrs. S. B. Russell, 114½ Grand Avenue West, Eau Claire, Wis. m3tfn

WANTED: USED EQUIPMENT of a physician. Young physician establishing private practice in Madison interested. Contact Dept. 34 in care of the Journal. m3tfn

GENERAL AND THORACIC SURGEON, Board certified, 36, American born, family, desires to practice in Wisconsin as associate, group, or solo. Contact Dept. 55 in care of the Journal. 5–6

WANTED: GENERAL PRACTITIONER or internist to take over immediately a large established practice on new northwest side of Milwaukee. Practice and office could accommodate two doctors if desired. New medical clinic building with all modern features includes private parking area, business office, large private office, four examining rooms, x-ray and laboratory facilities. Contact Dept. 56 in care of the Journal. m5tfn

GENERAL PRACTICE—Wisconsin—Established 9 years. Modern medical building to rent, 10 rooms, fully equipped including x-rays. Trained staff available. Two hospitals. Available June. Gross $40,000. Contact Dept. 54 in care of the Journal. 5–6

GROUP OF THREE desires general practitioner as associate. New clinic building with adequate facilities, in town of 5,500. Recent graduate preferable. Contact Plymouth Clinic, Plymouth, Wis. m4tfn

WANTED: Two young general practitioners to join 5-man group. Salary to start, early partnership western Wisconsin college town. Excellent hospital. Unlimited recreational facilities. Contact Dept. 50 in care of the Journal. 4–6

LOCATION WANTED: Either general practice or radiology or combination. Board eligible in radiology and experienced GP. Will serve several small hospitals in radiology, or will purchase retiring physician's equipment. Contact Dept. 51 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER, immediate full partnership in active practice now grossing $50,000, all advantages of dual practice with vacation periods and free weekends. No investment required. Full hospital privileges. Contact Dept. 53 in care of the Journal. m4tfn

ALLERGIST WANTED to share offices with dermatologist. Located in thriving area, south central Wisconsin. Unusual opportunity. Applicant must be board certified or qualified and intending to become certified. Reply, with details of personal and professional qualities and qualifications, to Dept. 5 in care of the Journal. m8tfn

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TWO INTERNISTS WANTED: Unusual opportunity to join a young multi-specialty group. Salary $18,000 first year with rapid acceleration to partnership. Exceptional clinic and hospital facilities in Midwest town of 30,000 which is the Medical Center of large trade area and a fine place to raise a family. Contact Dept. 44 in care of the Journal. 4–6

WANTED: INTERNIST for newly formed professional corporation in northeastern Wisconsin. Ideal living conditions and superior opportunity for advancement. Salary during first two years of association. Contact Dept. 25 in care of the Journal. 1tfn

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OUTSTANDING OPPORTUNITY for a young physician who is willing to work. Good schools, good 100-bed hospital. Good fishing and hunting. Retiring. Contact Dept. 32 in care of the Journal. m2–3tfn

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FOR RENT: OFFICE SPACE, 1200 sq. ft., for medical offices in modern, air-conditioned building at 16 East Gorham Street, Madison. Available for immediate occupancy. Will accommodate one or two physicians, preferably internists. Off-street parking. Contact Robin Allin, M.D., 1313 Fish Hatchery Road, Madison, Wis., phone ALpine 6–5521; or residence CEdar 3–2082. m8tfn

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FOR SALE: Hamilton examining and treating suite (table, cabinet, stool, waste container), like new, mahogany, reasonable. Contact Mrs. T. Huth, 7921 Livingston Ave., Wauwatosa, Wis., GLenview 3–4978. m5tfn

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WANTED: GENERAL PRACTITIONER or man with specialty who will do general practice and associate with one or two other men in well established practice. Fox River Valley. Immediate opening. Community of 50,000. Salary two years, then partnership. Contact Dept. 38 in care of the Journal. m4–5

WANTED: OPHTHALMOLOGIST for newly organized group in the Fox River Valley of Wisconsin. Community of over 50,000. Excellent living conditions, noted recreational area and above average opportunity. Salary two years then partnership. Contact Dept. 45 in care of the Journal. 4tfn

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WANTED: GENERAL PRACTITIONER to join general practitioner in well established practice in southeastern Wisconsin. Town of 8,000. Class A accredited hospital. Salary or partnership if mutually agreeable. Contact Dept. 39 in care of the Journal. m3–5

URGENTLY NEEDED: General Practitioner to become associated with small clinic group in Milwaukee, Wis., preferably one who has had practical experience and a special interest in obstetrics or industrial surgery. First year, salary; then profit percentage leading to partnership. Contact Dept. 48 in care of the Journal. m4tfn

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WANTED: GENERAL PRACTITIONER. Must be graduate of class A medical school, preferably with two-year internship from class A teaching hospital. Midwest industrial city of 46,000. Open staffed, fully equipped, 250-bed hospital. Equal partnership if satisfactory within two years. Excellent recreational facilities. Have well established general practice. Contact Dept. 57 in care of the Journal. m5tfn

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WANTED: GENERAL PRACTITIONER to replace retired physician in established three-man group. Must be interested in general medicine, obstetrics, and willing to assist in surgery. Fully equipped medical suite including x-ray and laboratory in town of 50,000 in Fox River Valley of Wisconsin. Unusual opportunity with eventual partnership. Contact Dept. 36 in care of the Journal. m3tfn

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WANTED: GENERAL PRACTITIONER to join physician in a large medical and surgical practice. Newly constructed clinic and 30-bed hospital. Beginning salary: $15,000 annually plus percentage. Good agricultural and industrial small town in the heart of Wisconsin. Finest recreational areas yet extremely close to the twin cities, Minneapolis and St. Paul. Contact Dept. 37 in care of the Journal. m3tfn

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PHYSICIAN WANTED: General practitioner in northeastern Wisconsin wants part time help. Can use one man or combination to cover practice for week, month, or up to a year. Money no object for right man. No OB or surgery unless desired. Living facilities and car available. Contact Dept. 29 in care of the Journal. m1tfn

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FOR SALE: Genophthalmic chair, Genophthalmic refractor, Claison projector, eye glass display cabinet, treatment table, records from eye, ear, nose and throat practice—42 years. Price very reasonable. J. J. Sharpe, M.D., 150 E. First St., Fond du Lac; telephone 291 and 349. m3tfn

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WANTED: PHYSICIAN to associate with two established general practitioners in southeastern Wisconsin industrial, agricultural community of 6,000. Prefer one who has had special surgical or obstetrical training and willing to do general practice along with surgery or obstetrics. Contact Dept. 31 in care of the Journal. m1–3tfn

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WANTED: Young, ambitious general practitioner needed at once at the Janesville Medical Center, 2020 E. Milwaukee St., Janesville, Wis. Salary for first year; and if mutually agreeable after one year, may become partner. Contact Duane F. Alexander, Business Manager. 3tfn

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GENERAL PRACTITIONERS for psychiatric treatment center. Present salary range $10,896–$14,196 with possibility of legislative increase July 1, 1963. Excellent comprehensive fringe benefit program, 40-hour week and limited furnished housing for single physicians or small families available at nominal cost. Please contact W. J. Urben, M.D., Superintendent, Mendota State Hospital, 301 Troy Drive, Madison, Wis. g4tfn

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GENERAL PRACTITIONER desires associate or partner. Liberal terms. No down payment. Two open staff hospitals. Plenty of work and plenty of recreational opportunities. A. B. Kores, M.D., Beaver Dam, Wis. m3tfn

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HELP! Two-man practice with only one man! General practitioner. Small town. Salary first year; partnership later. T. S. Westcott, M.D., 115 West Chestnut St., Pardeeville, Wis. m3tfn

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OCONOMOWOC: Modern six-room, air-conditioned, carpeted medical suite with separate entrances; July availability. This suite ideal for one or two GPs, physicians or specialists EENT, dermatology, orthopedics, pediatrics, psychiatry, needed in community. Modern hospital in city. Call: Milwaukee, UPtown 1–0390 or Oconomowoc 567–2492, or write: Rummel and Connolly, 155 East Wisconsin Avenue, Oconomowoc, Wis. 5

COMMERCIAL

WANTED: Advertisements for this new section. Open for physicians, individuals, firms, organizations who have something they would like to sell, or are looking for something to buy, or have a service available, which might be of interest to physicians.

The State Medical Society of Wisconsin

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N. A. Hill.....Madison
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Delegates to American Medical Association
(Terms end on December 31 of year indicated)

L. O. Simenstad, Osceola, 1964
E. L. Bernhart, Milwaukee, 1964
R. E. Galasinski, Milwaukee, 1963
A. A. Quisling, Madison, 1963

Alternates

John M. Bell, Marinette, 1964
G. J. Picard, Superior, 1964
George Collentine, Jr., Milwaukee, 1963
W. B. Hildebrand, Menasha, 1963

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	Wm. Smiles 522 W. 2nd St., Ashland	C. A. Grand 206–6th Ave., W., Ashland	
Barron–Washburn–Sawyer–Burnett	D. G. MacMillan Barron	J. K. Hoyer 40 W. Newton, Rice Lake	Second Tuesday 7:30 p.m.
Brown	John E. Dettman 519 S. Monroe Green Bay	Frank Urban Rm. 308, City Hall, Green Bay	Second Thursday°
Calumet	K. R. Humke Chilton	R. E. Knauf Chilton	
Chippewa	G. G. Shonat 100½ Bridge, Chippewa Falls	G. T. Bowe Gadott	Second Tuesday
Clark	E. Dolf Pfefferkorn Colby	Bahri Gungor Loyal	
Columbia–Marquette–Adams	R. T. Cooney 310 W. Conant St., Portage	J. W. Pavelsek, Jr. 122½ E. Cook St., Portage	Every Third Month 7:00 p.m.
Crawford	M. S. Garrity 610 East Taylor St., Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	R. N. Allin 1313 Fish Hatchery Rd. Madison	Gordon Davenport 110 E. Main, Madison	Second Tuesday°°
Dodge	Fred A. Karsten 514 E. Lake St., Horicon	Norman Erickson 302 N. Spring St., Beaver Dam	Last Thursday°
Door–Kewaunee	Patricia Lanier Kewaunee	E. W. Wits 213 Ellis, Kewaunee	
Douglas	L. R. Rosin 2231 E. 5th St., Superior	Enzo Krahl 324 Board of Trade Bldg. Superior	First Wednesday° Hotel Superior
Eau Claire–Dunn–Pepin	R. R. Richards 605 Walker Ave., Eau Claire	W. H. Walter 131 S. Barstow St., Eau Claire	Last Monday
Fond du Lac	G. M. Flannagan 80 Sheboygan St. Fond du Lac	W G. Kendell 92 E. Division St., Fond du Lac	Fourth Thursday°
Forest	O. S. Tenley, Wabeno	D. V. Moffet, Crandon	
Grant	G. L. Steidinger Platteville	H. W. Garey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	W. J. Fencil 921 16th Ave., Monroe	B. H. Brunkow 921 16th Ave., Monroe	
Green Lake–Waushara	Grant Stone 124 N. Wisconsin, Berlin	L. J. Seward 147 N. State St., Berlin	Last Thursday, every other month starting in Jan.

° Except June, July and August. °° Except July and August

List of Officers and Scheduled Meetings of County Medical Societies (Continued)

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	David Downs Dodgeville	E. J. Hohler Mineral Point	First Thursday following first Monday
Jefferson	E. A. Miller 133 Riverlawn Ave. Watertown	J. S. Garman 144 W. Madison, Waterloo	Third Thursday*
Juneau	J. H. Vedner Mauston	Jack Strong Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	J. J. Lutz 1202 60th St., Kenosha	G. F. Armstrong 6530 Sheridan Rd., Kenosha	First Thursday* Elks Club
La Crosse	George Skemp 312 State St., La Crosse	Ruth Dalton St. Francis Hosp., La Crosse	Third Monday
Lafayette	R. E. Hunter Argyle	L. L. Olson Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	John McKenna 1125 Superior, Antigo	First Monday
Lincoln	J. D. Millenbah 121 S. Mill St., Merrill	E. O. Ravn, Jr. 1802 9th St., Merrill	
Manitowoc	R. G. Yost 918 Washington St. Manitowoc	S. L. Kaner 1421 17th St., Two Rivers	Last Thursday
Marathon	R. H. Brodhead Box 838, Wausau	George Kordiyak 126 Grand Ave., Wausau	
Marinette–Florence	R. J. Maginn 1232 Mill St., Niagara	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	R. A. Frisch 425 E. Wisconsin Ave., Milwaukee	W. C. Curtis 10425 W. North Ave. Wauwatosa Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milw.	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	G. R. Sandgren Surm-	H. A. Aageson 1113 Main St., Oconto	
Oneida–Vilas	Allen Johnson Rhinelander	Marvin Wright 1020 Kahel Ave., Rhinelander	Monthly
Outagamie	F. M. Hauch 722 W. Lawrence St., Appleton	Wm. Chandler 402 W. Wisconsin, Appleton	Third Thursday* Elks Club
Ozaukee	R. F. Henkle 549 W. Grand Ave., Port Washington	P. W. Wallestad 502 W. Jefferson, Port Washington	
Pierce–St. Croix	H. J. Laney Prescott	P. H. Gutzler River Falls	Third Tuesday
Polk	Donald Fink St. Croix Falls	Lloyd L. Olson St. Croix Falls	Third Thursday 7:00 p.m.
Portage	Walter Gramowski 319½ W. Main St. Stevens Point	Albert Kohn 313 N. Fremont Stevens Point	
Price–Taylor	Walter E. Niebauer Phillips	John L. Rens Phillips	Last Saturday, Feb., May, Aug., and Nov.
Racine	W. H. Williamson 1101 Grand Ave., Racine	L. E. Jones 431 15th St., Racine Mr. G. N. Geraghty 600 Villa Street, Racine Exec. Sec.	Third Thursday
Richland	R. W. Edwards 118 West Mill St. Richland Center	L. M. Pippin 323 South Central Ave., Richland Center	First Thursday Richland Hospital
Rock	R. M. Baldwin 419 W. Pleasant St., Beloit	W. A. Scholten, Jr. 1146 Grant, Beloit	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	H. P. Baker Wonewoc	R. G. Knight 244 E. Main St., Reedsburg	Second Tuesday*
Shawano	H. F. Laufenberg Shawano	A. J. Sebesta Shawano	Third Wednesday
Sheboygan	Arthur C. Tompsett 920 Huron Ave., Sheboygan	J. F. Kovacic 708 St. Claire Ave., Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	Richard L. Holder 221 Main St., Black River Falls	J. H. Nohle 1109 Harrison Black River Falls	Fourth Tuesday
Vernon	Roy B. Balder, Jr. Elroy	C. A. Ender Viroqua	Last Wednesday
Walworth	Henry Mol Elkhorn	Rocco S. Galgano 610 Walworth, Delavan	Second Thursday*
Washington	James Albrecht 118 E. Main St., Jackson	James Algiers P. O. Box 110, Hartford	Fourth Thursday
Waukesha	Robert Feulner 630 Oxford Rd., Waukesha	W. E. Rosenkranz 720 N. Rochester, Mukwonago	First Wednesday
Waupaca	Georgo Dernbach New London	Lloyd P. Maasch Weyauwega	
Winnebago	R. H. Quade 116 So. Commercial St., Neenah	E. J. Zmolek 302 N. Main St., Oshkosh	First Thursday
Wood	F. John Gouze 650 S. Central Ave., Marshfield	John W. Rupel 650 S. Central, Marshfield	Four times a year

* Except June, July and August. ** Except July and August

INDEX TO ADVERTISERS

Abbott Laboratories ____ 12, 13
American Tobacco Company ____ 7
Ames Company ____ 57

Barr X-ray Co. ____ 24
Benson Optical Company ____ 41
Beutlich, Inc. ____ 23
Borden's ____ 43
Burroughs Wellcome & Co., Inc. ____ 4

Davies, Rose & Company, Ltd. ____ 8

Endo Laboratories ____ 15

Glenbrook Laboratories ____ 9
Great Lakes Corp. ____ 50

Haug Drug Company ____ 20
Hotel Schroeder ____ 27
House of Bidwell, Inc. ____ 24
Hurley X-ray Company ____ 43

Keeley Institute ____ 27

Lederle Laboratories ____ 38, 39, 47
Lilly and Company, Eli ____ Front cover, 18

Medical Protective Company ____ 14
Mid-Western Sport Togs ____ 27
Milwaukee Sanitarium Foundation ____ 43

Parke, Davis & Company ____ 2, 3
Physicians Exchange ____ 51, 52, 53
Physicians Mutual Insurance Co. ____ 24
Poythress & Co., Inc., Wm. P. ____ 16, 45

Rennebohm's ____ 43
Rogers Memorial Hospital ____ 14

Sacred Heart Sanitarium ____ 56
Saint Mary's Hill Hospital ____ 21
St. Croixdale Sanitarium ____ 4
Sardeau, Inc. ____ 32
Schering Corporation ____ 17
Searle & Co., G. D. ____ 19
Shorewood Sanitarium ____ 24
Smith Kline & French Laboratories ____ 46
Squibb & Sons, E. R. ____ 40

Tassette, Inc. ____ 22
Time Insurance Co. ____ 27
Tutag & Co., S. J. ____ 41

Wallace Laboratories ____ 10, 11, 30, 31, 44
Winthrop Laboratories ____ 29, 48
Wisconsin Physicians Service ____ 35

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the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

CONTENTS

VOL. 62, No. 6 JUNE 1963

SCIENTIFIC ARTICLES

Termination of Resistant Tachycardia by Cardiac Countershock, by David L. Morris, M.D., West Salem ---- 252

Hyperglycemia and Chlorothiazide, by J. F. March, M.D., Algoma ---- 257

Congenital Absence of the Gallbladder and Cystic Duct, by Kenneth A. Seifert, M.D., F.A.C.S., Milwaukee ---- 259

Clinicopathologic Conference, by Joseph M. Lubitz, M.D., Milwaukee ---- 262

SPECIAL FEATURES

President's Message to the House of Delegates, by W. J. Egan, M.D., Milwaukee ---- 241

Report on Iodine 131 in Milk ---- 242

Medicolegal Responsibility in the Prevention of Automobile Accidents, by Herman A. Heise, M.D., Milwaukee ---- 243

Alcoholism in Wisconsin, 1959–1961, by R. D. Nashold, M.S., and Horst Wadsack, M.S., Madison ---- 249

Find Your Future in the Health Field; a career guide ---- 248

Nonpolioviruses and Paralytic Disease (abstract) ---- 256

Comments on Treatment: Pharmacology—"A Justification", by Harold F. Hardman, M.D., Ph.D., Milwaukee ---- 268

Physicians Evaluate Little League Baseball ---- 273

Comments from the Press: Better to Know Than Wonder ---- 273

Minutes of Annual Council Meeting, Madison, February 23–24, 1963 ---- 274

Minutes of Special Council Meeting, Madison, April 6, 1963 ---- 280

Summary Report of the 122nd Annual Meeting of the House of Delegates, Milwaukee, May 6–9, 1963 ---- 283

EDITORIALS

Somehow Labor Speaks ---- 271

Distaff Dialectics ---- 272

REGULAR FEATURES

Letters of Interest ---- 7

List of Officers of State and County Medical Societies and scheduled meetings of County Medical Societies ---- 291

News of Wisconsin Physicians ---- 25

Facts about Wisconsin Physicians Service ---- 30

Society Records ---- 31

Medical Meetings ---- 37

Physicians' Exchange ---- 43

Index to Advertisers ---- 46

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Journal
Established 1903

Annual Subscription ---- $6.00
Single Copy ---- 1.00
Previous Years' ---- 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 303 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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LETTERS OF INTEREST

SURGERY IN THE FAR EAST

To SMS:

It was my good fortune to travel with a group of surgeons and to observe the practice of surgery in many countries of the Far East and Pacific areas. The average American surgeon has the mistaken impression that the surgeon in foreign lands is ill-informed and far behind the Americans.

After observing numerous surgical procedures in Japan and attending several surgical meetings, I came to the conclusion that their surgical knowledge and technique are equal to, and in some instances superior to, those in America. Dr. Juro Wada of Saporro, Japan, who was trained in the United States, performed open heart surgery for a patent foramen in the interatrial septum in 40 minutes. He used a pump which cost $200 in contrast to the expensive pumps used in this country. He is a dedicated man and performs open heart surgery every day. His knowledge and experience with thousands of cases of open heart surgery cannot be duplicated anywhere.

The Japanese are indefatigable workers. Dr. Kamei Nakayoma, professor of surgery at the University of Chiba (near Tokyo), has performed 2,000 operations for resection of the carotid body for intractable asthma with many excellent results. This operation has been infrequently performed in the United States. So perhaps the American surgeon should not be so smug and rest on past achievements, or our foreign competitors will surpass us. They have the advantage of having an unlimited supply of surgical patients.

Taipei (Taiwan) Formosa was next visited. There we found a well equipped new 1,000 bed hospital which is equal to any hospital in our country. This hospital has two modern cobalt machines. All types of surgery are performed. The surgical cases are divided into various groups. All the open heart and lung surgery patients are kept in one section, orthopedic patients in another, the brain cases in another and the general surgical cases in still a different section. It is a unique arrangement.

The Chinese people are frequently victims of nasopharyngeal cancer representing about 15 per cent of the carcinomas. The cause is unknown. Some believe that strong incense inhaled may be a factor. The first generation of Chinese in the United States are also subject to nasopharyngeal cancer, but subsequent generations are relatively free of this disease. Nasopharyngeal carcinoma represents less than one-half of one per cent of all the carcinomas in the United States.

Hong Kong, a city of 3,500,000 people, has one of the busiest harbors in the world. Forty ships a day leave this busy port. There are no urologists or plastic surgeons in this city. The 30 general surgeons are very well trained, some in England and some in the United States. They do all types of surgery such as hare lips and cleft palates, heart and lung surgery, cystoscopic examinations, prostatectomies and nephrectomies as well as all abdominal surgery. One of the common conditions in Hong Kong is caused by the liver fluke, carried by certain raw fresh water fish which are eaten uncooked. Tuberculosis is common and resection of lobes or entire lungs for tuberculosis is frequent since these people do not respond well to antituberculosis drugs. It was my pleasure to see Dr. Kenneth Hui, trained in New York, do a pulmonary resection for tuberculosis. Dr. E. H. Patterson resected a large congenital cyst of the liver and performed a right nephrectomy for multiple stones at the same time. The operation took only a little over one hour. Nylon is extensively used as suture material, apparently much more so than in the United States.

Bangkok, Thailand, is a city of two million population. There are 27 million people in the entire country. The surgeons are well trained and some are specialists. Open heart surgery is commonly done. One peculiar situation is the rarity of gallstones in the population. Urinary bladder stones are very common. The ratio of urinary bladder stones to gallstones is 10 to 1. No explanation is given for the large number of urinary bladder stones unless it is that the people drink very little water. Life expectancy is much shorter in Thailand and the diet is less rich than in the United States. These two conditions might account in part for the fewer cases of gallstones.

In Singapore, Malaya, carcinoma of the upper gastrointestinal tract occurs three times more frequently than in the United States. Carcinoma of the colon is only half as common. Carcinoma of the cervix is common. Keloid formation is frequent in wounds. There are still many leprous patients. Diphtheria is common, especially laryngeal diphtheria. Also otitis media and mastoiditis frequently occur. Carcinoma of the larynx is three times more frequent than in the United States, and nasopharyngeal carcinoma is often seen.

Sydney, Australia, a city of 2,600,000 population, is very modern. It has the sixth busiest harbor in the world. Many new medical buildings and hospitals are being constructed. The latest type of equipment is installed. The machine and pumps for open heart surgery are manufactured in Australia and are quite compact and efficient. Most of the surgeons have been trained in England, but they say in the future more will be coming to the United States. They believe United States surgery has surpassed that of England. There are two fine medical schools in Sydney, the Sydney Medical School and the University of New South Wales.

In New Zealand most of the surgeons have been trained in England. They left England because of the government control of medicine. It is impossible for a physician to earn more than $6,000 a year under government control, they said. While in Auckland, New Zealand, I witnessed several surgical procedures. One operation, an abdominoperineal resection for rectal carcinoma, was performed with two teams, one abdominal and the other perineal, working simultaneously. They have a special support for the legs so the legs aren't in the way of the abdominal or perineal surgeon. The operation was rapidly and well performed.

In the Fiji Islands medicine is practiced differently than in most parts of the world. In Suva there are hospitals, but elsewhere there are few. The medical training is also different. There is a medical school in Suva. Students are taken without any preliminary education and given five years training in practical treatment of diseases. They are given an M.P. degree, medical practitioner, not an M.D. degree. They are sent out in the brush and jungles to practice.

Tahiti has 40,000 population, and Papeete with 20,000 population is the principal city. There are two hospitals in Tahiti and 22 physicians. In France and French possessions, it is necessary to be a French citizen to be allowed to practice medicine. The people in Tahiti are very superstitious and witchery flourishes. Tuberculosis is the chief cause of death.

I am convinced that surgery in the United States is more difficult than elsewhere in the world. Our patients frequently weigh 160, 180 and sometimes over 200 lb., whereas most of the patients in foreign lands are skinny and usually weigh 100 to 120 lb. The difference is an abdominal wall 1 inch in thickness in one case and a wall frequently 6 or 8 inches in the other.

V. J. Hittner, M.D.
Seymour, Wisconsin

INFORMATION HELPFUL

To SMS:

I am extremely grateful to you for sending me the information concerning the role of the federal government in providing medical care.

On April 7, I competed in the Brookfield Central District Forensic Meet. I spoke on the role of the federal government in providing care to the indigent. The judge gave me an A, enabling me to speak in Madison on the 27th of April.

The topic at the State Meet dealt with the role of the federal government in providing health insurance. I stated that there is no need for an entirely new federal controlled program of health insurance and that grants-in-aid to the individual states would work just as well. My judge at State liked my arguments and presented me with an A.

Again, I thank you very much for your information.

Leonard Fox
Milwaukee

PROJECT HOPE NEEDS HELP!

Project Hope, the People-to-People Health Foundation, Incorporated, needs physicians for temporary duty in South America. The hospital ship "Hope" has returned to the United States and is presently in New York being refitted. The Project has three responsibilities in the offing:

(1) The University of Trujillo program, in Trujillo, northern Peru, where the ship was located for ten months in 1962 and 1963; the plan is to have a team of internists, surgeons, pediatricians, nurses and others to run a teaching program at the new Trujillo Hospital, a 210-bed institution which will open this summer. This is the continuation of last year's program with the ship, which was remarkably successful.

(2) The hospital ship itself is scheduled to go to Guayaquil, Ecuador, this fall. The ship ordinarily operates with a complement of about 25 physicians (a few full-time, most one, two, or three month rotators), and about 35 full-time nurses, technicians and administrators.

(3) There is a plan to operate a smaller ship on the upper Amazon, outfitted as a 50-bed hospital.

Project Hope needs people. You give of your time and your knowledge. They pay for your transportation, and most of your living while you are there. You can take your family if you can afford it! Several older sons of rotators have worked on the ship for periods of time and done splendid work.

Write to: Project Hope, The People-to-People Health Foundation, Inc., 1016—20th Street NW, Washington 6, D.C.

Two physicians from Wisconsin who have served on the Hope and can furnish details are Dr. James S. Vedder, 650 South Central Avenue, Marshfield, and Dr. William B. Gallagher, 312 State Street, La Crosse.

Jackson Clinic Spring Meeting

The spring postgraduate meeting of the Jackson Clinic and Foundation was held at the Park Motor Inn, Madison, on May 23. *Dr. John H. Morledge* was in charge of the first part of the program which included the following speakers: *Dr. Oscar F. Foseid* (general and thoracic surgery) whose topic was "Thoracotomy as a Diagnostic Procedure;" *Dr. Barbara A. Brew* (obstetrics and gynecology), "Eclampsia: A New Look at an Old Problem;" *Dr. Vaughn E. Demergian* (plastic surgery), "Restore, Repair, and Make Whole . . .;" and *Dr. William B. Parsons, Jr.* (internal medicine), "Polycythemic Syndromes in Occlusive Vascular Diseases."

Dr. Arnold S. Jackson, host for the meeting, conducted the second part of the program. *Dr. Donald S. Schuster* (dermatology), a guest speaker, discussed "Cutaneous Manifestations of Internal Diseases." Other speakers were: Dr. John H. Morledge (internal medicine), "Newer Diagnostic Approaches to Hypertension;" *Drs. Etheldred L. Schafer* (pathology), moderator, *Hubert C. Ashman* (internal medicine), *Luther E. Holmgren* (surgery), and *William L. Waskow* (radiology), (panel) Polyps of the Colon;" and *Dr. John J. Mueller* (urology), who acted as moderator for a question and answer period.

A social hour and supper followed presentation of the scientific program. Mr. Walter E. Scott, administrative assistant to the Director of Conservation, State of Wisconsin, was the guest speaker. His subject was "The Future of Conservation in Wisconsin."

Joins Staff of Quisling Clinic

Dr. Leif O. Torkelson has joined the Quisling Clinic in Madison in the department of internal medicine. Doctor Torkelson received his medical degree from the University of Virginia School of Medicine, Charlottesville, Va., after serving in the U. S. Navy during World War II and the Korean conflict. Following completion of residency training at the University of North Carolina and Duke University Affiliated Hospitals, Doctor Torkelson was engaged in research in cardiac rehabilitation in Cleveland where he was an instructor in medicine at Western Reserve University School of Medicine and a staff physician at Crile Veterans Administration Hospital.

Doctor Middleton Is "Retiring"

Dr. William S. Middleton retired in February as medical director of the Veterans Administration in Washington, D. C. The former dean of the University of Wisconsin is spending some time in Madison now but will become visiting professor of medicine at the University of Oklahoma July 1.

Physicians whose names appear in italic are members of the State Medical Society.

NEWS OF WISCONSIN PHYSICIANS

Plymouth Students Receive Scholarships

Three Plymouth High School graduates received scholarship awards from the Dr. H. F. Deicher Scholarship Award Fund recently. The awards were given the students presently enrolled in medical courses. Each award was for $150. The students are Charles Strub, Tim Zimmermann, and Phil Krueger. The first two are enrolled at the University of Wisconsin and the third one is enrolled at Baylor University, Houston, Tex. The Doctor Deicher scholarship fund is administered by the City Health Officer, City Attorney, President of Kiwanis Club, Chairman of Boys and Girls Committee of the Kiwanis and the Superintendent of Schools.

Doctors Lanier Practicing at Casco

Dr. Andrew S. Lanier and his wife, *Dr. Patricia Lanier,* of Kewaunee, are now practicing medicine at the Casco Clinic as well as in Kewaunee. They visit the clinic three days a week. The husband-wife medical team has been practicing in Kewaunee since 1955. The Casco Clinic was built as a community enterprise.

Doctor Beck Reelected to UF Post

Dr. John G. Beck, Sturgeon Bay, was reelected president of the Door County United Fund at the annual organizational meeting of the board of directors in April.

Fairchild Has Pair of Doctors

Drs. Bradley Garber and Robert Leasum, Osseo, have arranged to keep regular scheduled hours in a new six-room suite of offices set up for them by the Fairchild community which does not have a local physician.

Certified in Psychiatry

Drs. Judith Walton, Madison, and *John Koppa,* Milwaukee, have been certified in psychiatry by the American Board of Neurology and Psychiatry.

Fellowship in College of Physicians

Dr. Richard H. Wasserburger, chief of cardiology and assistant chief of medicine at Veterans Administration Hospital, Madison, and associate professor of clinical medicine, University of Wisconsin Medical School, was officially elected to fellowship in the American College of Physicians on Nov. 17, 1962.

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NEWS OF PHYSICIANS *continued*

Results of WSMGA Golf Tournament

Dr. John Garren, Jr., Kenosha, won the First Low Gross Trophy at the annual Spring Tournament of the Wisconsin State Medical Golf Association at the Kenosha Country Club on May 23 with a score of 77.

Drs. David Cookson, Madison, and *John Richards*, Kenosha, both scored 79 for the Second Low Gross. A flip of the coin decided Doctor Cookson as the winner. *Dr. Robert Urbanek*, Beaver Dam, was the recipient of the First Low Net Trophy.

Although the day's weather proved to be windy and cool, a part of the day a turnout of 123 played while 135 were present at dinner.

Other winners include: *Dr. William Swift*, Kenosha, Second Low Net; *Dr. John Fetherston, Jr.*, Milwaukee, Longest Drive on No. 4; *Dr. Stan Hollenbeck*, Milwaukee, Longest Drive on No. 9; Mel Smith, Closest to the Pin on No. 8; *Dr. R. W. Farnsworth*, Janesville, Closest to the Pin on No. 3.

Mel Smith, guest of Doctor Farnsworth, accomplished what all golfers dream of by shooting a hole-in-one on No. 8, a 195 yard par 3 hole.

Dr. Lemmer Visits Puerto Rico

Dr. Kenneth Lemmer, of the surgery department, UW, was in Puerto Rico in January to attend a MEND (Medical Education for National Defense) meeting. Doctor Lemmer succeeds *Dr. R. J. Samp* as coordinator of MEND for the United States. Doctor Samp, also of the surgery department, asked to be relieved of the assignment to devote more time to other duties.

Completes Course in Aerospace Medicine

Dr. Robert L. Bolton, of Milwaukee, has recently completed a course in Aerospace Medicine at Brooks AFB, San Antonio, Tex., and has now returned to his duties as director of professional services and chief of surgery at the USAF hospital, Larson AFB, Washington.

Dr. Kalb Travels Abroad

Dr. Clifford H. Kalb, a Milwaukee clinical allergist, has returned from a six-week tour with the American College of Chest Physicians. He attended the Grand Congress of Chest Physicians in New Delhi, India, February 20–25, during which he presented a paper on "Clinical Experiences with Repository Method in Treatment of Bronchial Asthma." He also was a participating panelist at pre- and post-Congress regional meetings of the College of Chest Physicians in Cairo, Jerusalem, Beirut, Bangkok, Hong Kong, and Tokyo.

Wisconsin Physicians New ACOG Fellows

Seven Wisconsin physicians were recently inducted new fellows in the American College of Obstetricians and Gynecologists. They are: *Drs. Edwin H. Barnes*, Kenosha; *C. Robert Jackson*, Madison; *John J. Brady*, *William C. Fetherston*, and *Howard Gass*, Milwaukee; *R. C. Wolfgram*, Oshkosh; and *Francis Gilbert*, Waukesha.

Attends Florida Symposium

Dr. Arnold H. Barr, Port Washington, attended the AMA Medicolegal Symposium held at the Americana Hotel, in Miami Beach, Fla., March 8–9.

Diplomates of Pathology Board

Six Wisconsin pathologists have been named diplomates of the American Board of Pathology. They are: *Drs. V. A. Baylon*, Janesville; *C. I. Bowerman*, Marshfield; *A. F. Cafaro*, Waukesha; *Jordon Frank*, Beloit; *Theodore Rowan*, Beaver Dam; and *R. A. Scheidt*, Milwaukee.

Medical Students Receive Fellowships

Two Wisconsin medical students have been awarded foreign fellowships which will enable them to obtain supervised medical experience in underdeveloped countries, the Association of American Medical Colleges has announced. They are: Norman J. James, Milwaukee, who is a junior in the University of Chicago School of Medicine, and Richard C. Reznichek, Madison, a junior in Northwestern University Medical School. Mr. James will go to Nepal and Mr. Reznichek to Cambodia. The fellowships are made possible by a grant from Smith Kline & French Laboratories. Mr. Reznichek is the son of *Dr.* and Mrs. *C. G. Reznichek* of Madison.

Dr. Tarrasch Takes California Post

Dr. Hertha Tarrasch, Janesville, a former Green and Rock county psychiatrist, has been named consultant to Dr. Danial Blain, director of the Cali-

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Cocktail Lounge
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The Beautiful EMPIRE Dining Room

Music and Dancing—At Lunch, Dinner, After Theatre

Music By America's Leading Bands
Air Conditioned

HOTEL SCHROEDER
MILWAUKEE
WALTER SCHROEDER, President

fornia State Department of Mental Hygiene. She began work this spring as a therapeutic supervisor in the State Institute for Mentally Ill at Atascadero, Calif.

Discontinues Limited Practice at Florence

Dr. Robert Stelle, Crystal Falls, has given up entirely his practice in Florence. He had been assisting the small community for the past year on a limited basis.

Viroqua Doctors in New Clinic

Drs. Lars Gulbrandsen and *David, Edward* and *DeVerne Vig* moved into their new clinic building this spring.

Tomahawk Jaycees Honor Dr. Bugarin

The distinguished service award of the Tomahawk Junior Chamber of Commerce was recently presented in absentia to *Dr. Nunilo L. Bugarin.* It was accepted by his partner, *Dr. R. J. Henderson,* at an award dinner. Doctor Bugarin and his family were on a vacation in his native Philippines when the award was presented. Doctor Bugarin, who has been in the United States since 1955, was chief resident of Milwaukee Deaconess Hospital before moving to

as sure as time itself . . .

YOUR INCOME WILL STOP

Somedoy, suddenly, your income will no longer exist. The discreet professionol mon provides o substitute income for those who depend on his eorning power. In one balanced plan, Time Insurance provides income for the unknown inevitoble . . . disability, death or retirement. It's the foresight, not the cost.

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OVER 80 YEARS' SPECIALIZED EXPERIENCE IN THE RESTORATIVE TREATMENT OF

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- the most modern, coordinated, comprehensive, rehabilitative regimen
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- full cooperation throughout with the referring physician
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

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WE WELCOME YOUR REFERRALS...

THE KEELEY INSTITUTE
DWIGHT, ILLINOIS

Member American Hospital Association, Member Illinois Hospital Association. Licensed by the Department of Public Health, State of Illinois.

Tomahawk in 1961. He is a member of the Jaycees and a director of the Tomahawk Area Corp., an industrial development group.

Dr. Orth Consultation in New Orleans

Dr. O. Sidney Orth, anesthesiologist at the UW Medical Center, was in New Orleans, La., earlier this year for a consultation regarding the experimental drug, INDOKLON (hexafluorodiethyl ether).

Dr. Feulner Speaks on Medicare

Dr. R. C. Feulner, Waukesha, president of the Waukesha County Medical Society, spoke on medicare at a meeting of the city-town branch of the Waukesha Republican party. Doctor Feulner is a radiologist at Waukesha Memorial hospital.

Newspaper Features Bonduel Couple

The GREEN BAY PRESS-GAZETTE recently featured a Bonduel husband and wife doctor team. *Dr. W. W. Grover* and his wife, *Dr. Patricia Stuff*, serve the Shawano County community. Doctor Grover graduated from the University of Colorado medical school in 1950; Doctor Stuff graduated from Women's Medical College of Pennsylvania.

Dr. Jochimsen Attends Washington Meeting

Dr. E. H. Jochimsen, of the Sheboygan Clinic, attended a conference of the American Ortho-Psychiatric Association in Washington, D.C. this spring.

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1924 W. Clybourn St. WEst 3–1300

MILWAUKEE 3, WISCONSIN

Has available at all times a complete line of film and chemicals, plus the equipment and accessory items needed to make your X-ray department operate efficiently.

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To Serve Your Complete Orthopedic, Prosthetic & Surgical Appliance Needs

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For Nervous Disorders

A 65-bed institution for the treatment of nervous and mental illnesses.

Illustrated booklets sent on request.

WM. H. STUDLEY, M. D.
Medical Director

JOHN A. STEMPER, M. D.

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Facts about

WISCONSIN PHYSICIANS SERVICE

The following excerpt is from the Report of the Reference Committee on Resolutions and Amendments to the Constitution and ByLaws to the House of Delegates—May 8, 1963.

> "Your Committee wishes to commend the Commission on Medical Care Plans for its direction of Wisconsin Physicians Service and the progress made in attaining desired goals."

GOALS ATTAINED IN 1962

. . . Pushed Surgical-Medical Contract Count over 100,000 mark once again.

. . . Increased reserves to all time high (almost $2½ million).

. . . Surpassed $10,000,000 mark in earned premiums.

. . . Consolidated entire staff of WPS under one roof.

Summary of 1962 experience and comparison with previous year*

	Earned Premium	Total Contract Count	(Hosp-Surg-Med) Loss Ratio	Reserves
1962	$11,034,739	189,953	85.8	$2,479,817
1961	9,707,643	160,429	83.4	2,016,752

* This summary highlights 1962 activities of WPS. A complete financial report will be provided in a following issue of WMJ.

THE DOCTORS' PLAN OF THE STATE MEDICAL SOCIETY

WPS SURGICAL MEDICAL HOSPITAL

WISCONSIN PHYSICIANS SERVICE

330 E. LAKESIDE MADISON 1, WISCONSIN ALPINE 6-3101

MEMBERSHIP REPORT AS OF MAY 15, 1963

NEW MEMBERS

George L. Apfelbach, 2020 East Milwaukee Street, Janesville.
Michael Barton, 907 Main Street, Oconto.
Merle M. Bermann, 810 East Brown Deer Road, Milwaukee.
Calvin O. Chicks, Suite 211–212 Monterey Building, Janesville.
Ralph A. Clark, 8700 West Wisconsin Avenue, Milwaukee.
G. L. Clinton, 301 Troy Drive, Madison 6.
W. A. Corcoran, Jr., 549 West Grand Avenue, Port Washington.
Richard A. Damon, 345 North Madison Street, Waupun.
Joseph C. Darin, 8700 West Wisconsin Avenue, Milwaukee.
Donald W. Dohnalek, River Falls Clinic, River Falls.
William J. Duxbury, Fox Lake.
Manfred Effenhauser, McDonald Clinic, Winneconne.
Oscar A. Farias, Middle River Sanatorium, Hawthorne.
William A. Finger, 5262 North Diversey, Milwaukee.
Bradley G. Garber, Osseo.
Eugene V. Grace, Monroe Clinic, Monroe.
Bruce E. Greenfield, 416 College Street, Beloit.
B. O. Gungor, Loyal Medical Center, Loyal.
Conrad M. Heinzelmann, 2204 West Kendall Avenue, Milwaukee.
Harold J. Hoops, Jr., 130 East Walnut Street, Green Bay.
Joseph R. Kelly, 1505 Main Street, Stevens Point.
Gerald C. Kempthorne, Spring Green.
Leslie G. Langlois, 161 West Wisconsin Avenue, Milwaukee.
Robert N. Leasum, Jr., Osseo.
Jack R. Lees, Marshfield Clinic, Marshfield.
John B. Lefsrud, 1836 South Avenue, La Crosse.
John J. Massart, 3305 North 55th Street, Milwaukee 16.
Floyd E. Morbeck, 9008 West Burleigh Street, Milwaukee.
Leo K. Nelson, St. Croix Falls Clinic, St. Croix Falls.
Robert F. O'Boyle, 401 North Oneida, Appleton.
James N. O'Brien, 500 West Milwaukee Street, Janesville.
Ralph N. Olsen, 949 Glenview Avenue, Milwaukee.
Richard S. Ostenso, Marshfield Clinic, Marshfield.
George E. Owen, 314 Grand Avenue, East, Eau Claire.
D. E. Papendick, 801 Fourth Street, Algoma.
William B. Rabenn, 8828 North Port Washington Road, Milwaukee.
Branko Radich, Winnebago State Hospital, Winnebago.
Warne F. Ramsey, 1210—15th Avenue, Menomonie.
John M. Reinemann, 1011 North 8th Street, Sheboygan.
John D. Riesch, W 17970 Sheperd Drive, Menomonee Falls.
Cleon L. Schultz, 1300 University Avenue, Madison.
Donald L. Sherwood, 1066 Mather Street, Green Bay.
Rodolfo G. Simeon, 402 Madison Street, Lancaster.
William H. Snook, Fox Lake.
Richard B. Solomon, 1300 University Avenue, Madison 6.
David S. Trump, 1650 North 116th Street, Milwaukee.
Nicholas R. Wagener, 802 North 3rd Avenue, Sturgeon Bay.
Thomas F. Way, 1416 Chandler Street, Madison.

CHANGES OF ADDRESS

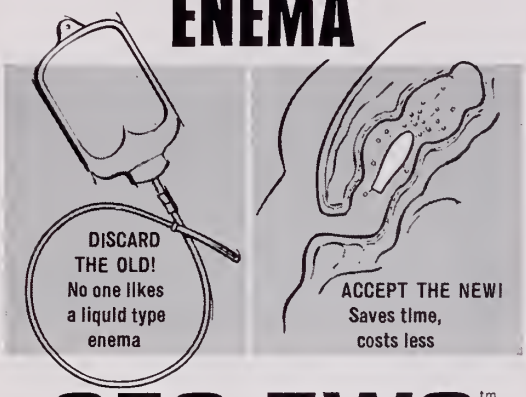
Robert T. Adlam, to 5242 North Kent Avenue, Milwaukee 17.

SOCIETY RECORDS

Howard Albright, Milwaukee, to 143 Green Bay Avenue, Thiensville.
Edwin P. Bickler, to 6001 West Center Street, Milwaukee.
J. M. B. Bloodworth, Jr., to Department of Pathology, University of Wisconsin, 426 North Charter Street, Madison 6.
J. D. Bonan, Milwaukee, to 10425 West North Avenue, Wauwatosa 13.
William McKinley Brown, Jr., Altadena, Calif., to 111 East First, Los Angeles 12, Calif.
B. H. Brunkow, to 921—16th Avenue, Monroe.
R. G. Burnett, to 7314 Third Avenue, Kenosha.
David V. Cookson, to 4910 Lake Mendota Drive, Madison 5.
William C. Curtis, to 10425 West North Avenue, Wauwatosa 13.
Jean P. Davis, to 111 East Wisconsin Avenue, Milwaukee.
Anthony Domine, to 412 North Segoe Road, Apt. 55A, Madison 5.
Haydon R. Duffy, to 1915 West Hampton Avenue, Milwaukee.
Richard Foregger, to P. O. Box 4273, Milwaukee 10.
Edgar A. Hawk, to 2707 Marshall Court, Madison.
H. J. Heath, San Diego, Calif., to 157 West North Street, Juneau.
Ann B. Henschel, Milwaukee, to 910 North Elm Grove Road, Elm Grove.
V. H. Hunkel, to 10425 West North Avenue, Milwaukee 13.
J. E. Hutchins, to 9235 West Capitol Drive, Milwaukee.
J. J. Jacoby, Elm Grove, to 7966 North Beach Drive, Milwaukee.
E. M. Juster, to 730 Miami Pass, Madison.
John T. Klein, to 5530 North Lake Street, Milwaukee 17.
Robert E. Klingbeil, Milwaukee, to 910 North Elm Grove Road, Elm Grove.
Milton G. Klumb, to 2409 North 47th Street, Milwaukee.
A. J. Knauf, to 1211 North 6th Street, Sheboygan.
Amrum Lakritz, Milwaukee, to 1 East Milwaukee Street, Janesville.
Myron N. Lovett, to 1212 West Wisconsin Avenue, Milwaukee 3.
Sidney Lubar, to 208 East Wisconsin Avenue, Milwaukee 2.
George S. Metcalf, to 1213 Columbus Circle, Janesville.
William S. Middleton, Washington, D.C., to 2114 Adams Street, Madison.
G. F. Mueller, Jr., to 606 Irving Zuelke Building, Appleton.
William H. Nicolaus, Madison, to Box 513, Green Bay.
Marilyn J. O'Brien, La Crosse, to 8 South Busse Road, Mt. Prospect, Ill.
Edward P. Onderak, Greendale, to 2200 West Kilbourn Avenue, Milwaukee.
Philip E. Podruch, Madison, to 9112 West Blue Mound Road, Milwaukee 13.
Maurice J. Reuter, Sr., Milwaukee, to 320 East Ravine Drive, 108 North, Mequon.
James A. Schelble, to 3073 North Shepard Avenue, Milwaukee.

New!

CARBON DIOXIDE ENEMA



CEO-TWO™

RECTAL SUPPOSITORY

SUBSTITUTES CO_2 FOR H_2O

Produces about 350 cc of carbon dioxide. Gently distends the rectal ampulla to trigger the defecation reflex.

Physiologic in Action
(for lower bowel evacuation only)

Ceo-Two is painless, safe, easy-to-use, clean, predictable and effective in 5 to 20 minutes. Preferred by both patient and nurse.

INDICATIONS: Ante and Postpartum, Pre and Postoperative or whenever the last 25 cm. of the lower bowel must be emptied.

CONTRAINDICATIONS: As with other enemas or laxatives. There are no known side effects.

Each 6.7 gram Ceo-Two suppository contains . . .
Sodium Biphosphate 1.6 gm.
Sodium Bicarbonate 1.4 gm.
in a water soluble polyethylene glycol base buffered to pH 7.0. For additional information, refer to current PDR.

ADULT DOSAGE: One Ceo-Two™ suppository is usually sufficient to induce defecation. Moisten with *water only* before insertion. Have patient retain 5 to 7 minutes or as long as possible.

Available at all Pharmacies. Supplied: in packages of 10 suppositories. No refrigeration required.

Beutlich INC.
CHICAGO 45, ILLINOIS

Write for samples

DOCTOR
ADDRESS
CITY ZONE STATE

SOCIETY RECORDS *continued*

Clayton H. Schmidt, Omaha, Neb., to 1220 Sunset Drive, Bellevue, Neb.
Stephen Sipos, to 8104—22nd Avenue, Kenosha.
W. C. Southcott, to 6934 North Seneca Avenue, Milwaukee 17.
Gerald O. Stubenrauch, West Allis, to 7635 West Oklahoma Avenue, Milwaukee.
Hertha Tarrasch, Janesville, to Atascadero State Hospital, Atascadero, Calif.
Howard M. Templeton, Stevens Point, to 725 Lakeview Drive, Wausau.
Richard R. Whereatt, Janesville, to 1226 Fischer Street, Munster, Ind.
George J. Worm, Milwaukee, to 10425 West North Avenue, Room 320 Fairview Building, Wauwatosa.
John J. Zaun, Jr., Winchester, to 823 Saranac Avenue, Mesa, Ariz.
G. R. Zupnik, to 606 West Wisconsin Avenue, Suite 414, Milwaukee.

REMOVED FROM MEMBERSHIP

William J. Blake, Milwaukee county, transferred to Maryland.
John O. Cales, Green county, transferred to Illinois.
Roland H. Corbet, Milwaukee county, transferred to Pennsylvania.
Helen Crawford Davis, Marathon county, resigned.
David L. Dean, Dane county, resigned.
Louis J. Filiatrault, Barron-Sawyer-Washburn-Burnett county, transferred to Minnesota.
Carol M. Franklin, Milwaukee county, transferred to California.
Donald A. Franklin, Milwaukee county, transferred to California.
David H. Gatherum, Milwaukee county, transferred to West Virginia.
Paul T. Gilles, La Crosse county, removed per county secretary.
Donald M. Green, Marathon county, removed per county secretary.
Roger E. Henning, Winnebago county, removed per county secretary.
M. Rateb K. Homsi, Milwaukee county, transferred to Michigan.
Edward T. Hougen, Sheboygan county, removed per county secretary.
Ernest N. Krueger, Outagamie county, resigned.
Harry Mannis, Monroe county, removed per county secretary.
Francis D. Murphy, Jr., Milwaukee county, transferred to California.
Robert W. Schmitt, Oneida-Vilas county, transferred to Indiana.
S. W. Simonson, La Crosse county, resigned.

DEATHS

Cyril F. Turney, Milwaukee, Milwaukee county, March 27.
Donald W. Curtin, Kimberly, Outagamie county, March 17.
Merlin C. Briggs, Milwaukee, Milwaukee county, April 11.
John J. Kazmierowski, Milwaukee non-member, April 15.
Arthur J. Knauf, Sheboygan, Sheboygan county, April 15.
Eugene L. Dallwig, Milwaukee, Milwaukee county, April 20.
Joseph A. Kelly, Chippewa Falls, non-member, April 13.
Jeremy J. Sharpe, Fond du Lac, Fond du Lac county, April 30.
Claude F. Schroeder, Milwaukee, Milwaukee county May 3.

CALENDAR OF MEETINGS

1963 **Wisconsin**

Oct. 20–23: Annual District VI meeting of American College of Obstetricians and Gynecologists, Milwaukee.

Nov. 21: Eberbach Memorial lecture honoring Milwaukee Hospital centennial, by Dr. Carl E. Badgley, professor of orthopedic surgery, University of Michigan School of Medicine, Milwaukee.

1963 **Out-of-State**

July 8–10: Postgraduate course on Obstetrics and Gynecology, University of Colorado Medical Center, Denver.

July 12–13: Rocky Mountain Cancer Conference, Brown Palace Hotel, Denver, Colo.

July 15–19: Second International Conference on Congenital Malformations sponsored by The National Foundation–March of Dimes, Americana Hotel, New York City.

July 18–20: Postgraduate course on Dermatology, University of Colorado Medical Center, Denver.

Aug. 5–9: Postgraduate course on Pediatrics, University of Colorado Medical Center, Estes Park.

Aug. 19–23: Medical Audiology Workshop, University of Colorado Medical Center, Denver.

Aug. 21–23: Regional seminar for American Medical Examiners, University of Minnesota.

Aug. 26: Annual meeting of American Academy of Physical Medicine and Rehabilitation, Sheraton–Dallas Hotel, Dallas, Tex.

Sept. 16–28: Course in Laryngology and Bronchoesophagology, University of Illinois College of Medicine, Chicago.

Sept. 16–20: Pulmonary Disease Seminar, University of Colorado Medical Center, Fitzsimons General Hospital, Denver.

Sept. 25–26: National Congress on Occupational Health, sponsored by the AMA's Council on OH, San Francisco.

Oct. 12–13: Annual meeting, The Mid West Allergy Forum, Sheraton-Cleveland Hotel, Public Square, Cleveland, Ohio.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, sponsored by the Council on International Affairs of the American College of Chest Physicians, Mexico City.

Oct. 13–19: XVIIth World Medical Assembly (originally scheduled in Mexico City Sept. 22–28), Commodore Hotel, New York City.

Oct. 14–18: Course in Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, International Inn, Washington D. C., American College of Chest Physicians.

Oct. 14–18: Course in Sources and Use of Toxicological Information, Institute of Industrial Medicine, New York University Medical Center, Onchiota Conference Center, Tuxedo, N.Y.

Oct. 16–19: Conference on Obstetric, Gynecologic and Neonatal Nursing, sponsored by District VI, American College of Obstetricians and Gynecologists, Chicago.

Oct. 21–22: 1963 Scientific Session of American Cancer Society—A conference on "Unusual Forms and Aspects of Cancer in Man", Biltmore Hotel, New York City.

Oct. 21–25: Course in Clinical Cardiopulmonary Physiology, American College of Chest Physicians, Pick Congress Hotel, Chicago.

Oct. 24–26: Course in Postgraduate Gastroenterology, American College of Gastroenterology, Washington, D. C.

Oct. 23–25: Chiefs-of-staff Conference, University of Colorado Medical Center, Denver.

Nov. 5–13: Ninth Congress of the Pan–Pacific Surgical Association, Honolulu, Hawaii.

Nov. 11–15: Course in Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Barbizon Plaza Hotel, New York City.

Nov. 22–25: Annual convention, National Society for Crippled Children and Adults, Palmer House, Chicago.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Nov. 13–Dec. 10: First Pan–Pacific Mobile Educational Lecture Seminar, New Zealand, Australia, Thailand, the Philippines, Hong Kong and Japan.

Nov. 18–21: Annual meeting of the Southern Medical Association, New Orleans, La.

Dec. 2–6: Course in Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Ambassador Hotel, Los Angeles.

1964

Jan. 13–17: Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Hotel Fontainebleau, Miami Beach.

Rocky Mountain Cancer Conference

Dr. Edward R. Annis, president-elect of the American Medical Association, will be one of the principal speakers at the 17th Annual Rocky Mountain Cancer Conference, July 12–13, at the Brown Palace Hotel in Denver, Colorado.

Speakers on the two-day scientific program include: James C. Doyle, M.D., (Ob-Gyn), Beverly Hills; Edward A. Gall, M.D., Director Department of Pathology, Cincinnati General Hospital and Editor in Chief of the American Journal of Pathology; Olof H. Pearson, M.D., Associate Professor of Laboratory Medicine, Western Reserve Medical School; Henry L. Jaffee, M.D., Director Division of Radiation Therapy and Nuclear Medicine, Cedars of Lebanon Hospital; Howard R. Mahorner, M.D. (Surgeon) New Orleans; Murray M. Copeland, M.D., Professor of Oncology, University of Texas Postgraduate School of Medicine, Houston, will represent the American Cancer Society at the meeting.

The first day of the Conference will be devoted to scientific papers presented by the guest speakers. A panel discussion featuring the guest speakers and entitled "Available Methods in the Treatment of Persistent Cancer," will highlight the morning session of of the second day. A Round-Table Forum will follow the panel in the afternoon.

Application has been made for A.A.G.P. accreditation of the Conference.

The Rocky Mountain Cancer Conference, held annually in Denver, is co-sponsored by the Colorado Division of the American Cancer Society and the Colorado Medical Society.

Further information may be obtained by writing Rocky Mountain Cancer Conference, 1809 East 18th Avenue, Denver 18, Colorado.

Question:

"What is a tranquilaxant?"

Answer:

"A drug that is both a tranquilizer and a muscle relaxant."

TRANCOPAL®
brand of
chlormezanone
is a tranquilaxant

As a tranquilizer, TRANCOPAL (chlormezanone/Winthrop) "is effective in the symptomatic treatment of anxiety."[1] Its tranquilizing properties are similar to those of other mild tranquilizers.[1] Furthermore, it relieves tension of both mind and muscle without interfering with normal activity or alertness.

The muscle relaxant properties[2] of this drug provide an extra dimension of effectiveness...relaxing the spasm which so frequently accompanies psychogenic disorders. Hence, the total therapeutic effect of TRANCOPAL (chlormezanone/Winthrop)—a true "tranquilaxant"—is to produce a relaxed mind in a relaxed body.

Unsurpassed Tolerance: Less than 3 per cent of patients develop side effects with TRANCOPAL (chlormezanone/Winthrop), such as occasional drowsiness, dizziness, flushing, nausea, depression weakness and drug rash. If severe, medication should be discontinued. In most patients, however, side effects are minor and do not necessitate interruption of treatment. There are no known contraindications.

Available: 200 mg. Caplets® (green colored, scored) 100 mg. Caplets (peach colored, scored), each in bottles of 100.

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; in some patients 100 mg. three or four times daily suffices. Children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Winthrop
WINTHROP LABORATORIES
New York 18, N.Y.

References: 1. A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963. 2. Gruenberg F.: Curr. Ther. Res. 2:1 (Jan.) 1960.

Classified Advertisements

Advertisements in this section are accepted in two categories: PHYSICIANS' EXCHANGE and COMMERCIAL.

RATES: 10¢ per word, with a minimum charge of $4.00 per ad. Additional insertions of same ad at one-half price each, maximum time one year. Display: $10.00 per column inch.

DEADLINE: Copy must be received by the 15th of the month preceding month of issue. Send copy to: Wisconsin Medical Journal, Box 1109, Madison 1, Wis.; or phone Alpine 6–3101.

PHYSICIANS' EXCHANGE: This section is limited to physicians and others desiring physician placement, sale of medical practice or equipment of a physician, sale or lease of medical buildings, etc. Advertisements from individual members of the State Medical Society of Wisconsin are accepted without charge. Widows of deceased member physicians are allowed to advertise without charge. The rates quoted above apply to ads placed by clinics and others. There is no additional charge for ads with Dept. numbers. For these ads, address replies to: Dept. ___, % Wisconsin Medical Journal, Box 1109, Madison 1, Wis. Advertisers using Dept. numbers forbid the disclosure of their identity. All inquiries are forwarded to them immediately.

COMMERCIAL: Advertisements are accepted at the above rates from individuals, firms, organizations, etc., who are reputable, have a good credit rating and advertise products or services of ethical standards. The Journal reserves the right to reject any advertising. Advertisements from member physicians are also accepted at the above rates.

PHYSICIANS' EXCHANGE

WANTED: INTERNISTS—GENERAL PRACTITIONERS in college health service at the University of Wisconsin. Excellent opportunity. Possibilities of academic appointment. Salary $11,000–$15,000, dependent on qualifications. Contact Peter L. Eichman, M.D., Director of Student Health, University of Wisconsin, 1300 University Avenue, Madison 6, Wisconsin. g6tfn

GENERAL PRACTICE: A location available with living quarters. A fine potential for an individual. Webster & Larsen, Realtors, Hudson, Wis. p6

FOR SALE: UNOPPOSED small town general practice, southwestern Wisconsin. Modern, well equipped, air conditioned building, excellent open staff hospital nearby. Annual gross over $50,000. Contact Dept. 999 in care of the Journal. m8tfn

WANTED: Certified or qualified specialist in—

1. Psychiatry
2. Neurology
3. Plastic Surgeon
4. Pathology
5. Anesthesiology
6. Ophthalmology
7. Proctology

also Registered Pharmacist and EEG Technician to join 28-man, all-specialist group. Contact Harold E. Scherer or Robert G. Zach, M.D., The Monroe Clinic, Monroe, Wis. 4tfn

FOR SALE: Established EENT practice, over 40 years in the heart of Milwaukee. Excellent referrals; will introduce; retiring. Contact Dept. 24 care of the Journal. m12tfn

OFFICE SPACE for two or three physicians, OB or two surgeons. To rent or to sell. Pharmacy in same building. Contact Dept. 33 in care of the Journal. m3tfn

WANTED: GENERAL PRACTITIONER as associate. Immediately available opportunity to practice in well established group of two. Replacement for sudden loss of partner. Eventual partnership. 126 E. Main Street, Madison. AL 6–3171. m9tfn

INTERNIST, Board eligible, Hines VA trained, completing army duty presently, 1957 Marquette graduate, desires location and association in Milwaukee or suburbs August 1963. Nilandino Oddis, M.D., 868 B. Grant Road, Ft. Devens, Mass. p6

PHYSICIANS MEDICAL CLINIC: Ground level, 1600.2' Partitioned—air-conditioned—parking—new fertile suburban area, city of Milwaukee. Reasonable rental. Near hospitals. Dentist in building will assist physician in establishing practice. RARE opportunity. Call ATlantic 1–7060, Dr. Y. Wasserman, Dentist, 4348 S. 27th. 6

WANTED: GENERAL PRACTITIONER as a replacement in town of 1,275 in southern Wisconsin. Gross receipts $42,000 in 1961, over $24,000 first 6 months 1962. Unopposed, good schools, churches, roads, fishing. Nearby accredited 200 bed hospital. Leaving for residency. Contact: D. L. Minter, M.D., Clinton, Wis. m9tfn

WANTED: PSYCHIATRISTS or young doctors, interested in psychiatry to work at Mendota State Hospital. These positions are permanent and under Civil Service; salary depends upon previous experience and training. Housing available on grounds. Contact W. J. Urben, M.D., Superintendent, Madison 4, Wis. g10tfn

FOR SALE: Two level home and office on bank of river; 45-acre estate near town of 6,000, 70 miles north of Madison. Hospital, good schools, several churches. Man with surgical training desirable. Purchase may be made by land contract. Might consider a locum tenens with potential permanent arrangement. A highly flexible opportunity for the right person. Contact Dept. 23 in care of the Journal. m12tfn

WANTED: INTERNIST, Board certified, to join two established surgeons. Excellent office facilities. Opposite 300-bed hospital—200-bed added expansion in progress. Town of 15,000. Central Wisconsin. Guaranteed salary. Percentage and partnership early prospects. Contact Paul F. Doege Medical Center, 512 St. Joseph Ave., Marshfield, Wis. m3tfn

WANTED: GENERAL PRACTITIONER for association with two-man group located near Madison. Excellent hospital and recreational facilities. Salary open to start with partnership opportunity at end of one year. New building with excellent equipment and personnel. Contact Dept. 52 in care of the Journal. m4tfn

PHYSICIANS, with or without pediatric training, needed in maternal and child health program at salaries ranging from $9,960.00 to $13,200.00. Five-day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, Milwaukee Health Department, Municipal Building, Milwaukee 2, Wis. g8tfn

GENERAL PRACTICE FOR SALE. Physician desiring own x-ray equipment may purchase radiographic, fluoroscopic and therapy equipment. Seven-room office on main corner in southern Wisconsin city of 35,000 occupied for over 40 years. Wish to retire. Reasonable price. Contact Dept. 19 in care of the Journal. m11tfn

PARTNER IN GENERAL PRACTICE WANTED in Green Lake county, town of 5,000. Fifty-bed private hospital. Five grade schools and one high school. No predominant nationalities. Various churches. Main occupations are leather, fur and metal. Contact Dept. 20 in care of the Journal. m11tfn

WANTED: PHYSICIAN with military service fulfilled to associate with a general surgeon also in general practice in northeastern Wisconsin in a city of 75,000. Excellent salary leading to early partnership. This is an A-1 financial opportunity. An early interview is appreciated. Contact Dept. 43 in care of the Journal. m4tfn

URGENTLY NEEDED: Associate going for residency—another man urgently needed. Twelve miles east of Fond du Lac, Catholic rural area. Start at $1,300 or more monthly. No investment. Available June. Contact Jos. F. Miller, M.D., Mt. Calvary, Wis. m4tfn

WANTED: INTERNIST, Board certified or eligible for association with young internist in southeastern Wisconsin city of 90,000. Contact Dept. 980 in care of the Journal. m4tfn

FOR SALE: IN WISCONSIN. General practice, well established, same location 40 years, fully equipped 7-room office. Will take any reasonable offer and finance as you wish. Poor health forces retirement. Contact Dept. 912 in care of the Journal. m4tfn

WANTED: PHYSICIAN to share a clinic which is now occupied by an M.D. and a D.D.S., located in a prosperous southeastern Wisconsin industrial and farming community where the need for another physician is very great. Contact Dept. 827 in care of the Journal. 4tfn

FOR SALE: PEDIATRICS PRACTICE in suburb of large Wisconsin city; will introduce; buyer assume two-year lease; open hospital staff; physician leaving Sept. 1, 1962, for academic post. Contact Dept. 985 in care of the Journal. m5tfn

ST. PAUL: General practitioner needed to fill third position with two 39-year-old AAGP members. Own beautiful, air-conditioned office building. Salary related to experience and early partnership desired. Contact Dept. 49 in care of the Journal. 4–6

WANTED: GENERAL PRACTITIONER to become associated with small group in central Wisconsin, preferably one who has had some practical experience, and has a special interest in obstetrics; also willing to only assist in surgery. Contact Dept. 969 in care of the Journal. m2tfn

ADDITIONAL OBSTETRICIAN–GYNECOLOGIST for northern Minnesota general practice and specialty group. Early partnership. Contact A. M. Antonow, M.D., East Range Clinic, Virginia, Minn. 4–6

OFFICE SPACE in medical clinic, 2218 North Third Street, Milwaukee, Wis.; Co. 4–2800. m3tfn

WANTED: GENERAL PRACTITIONER to replace physician who left for residency training. Fully equipped office available immediately. Town of 2,100 offers good hospital, skiing, hunting, golf, fishing and many other recreational advantages along the Chippewa River near its junction with the Mississippi. Financial remuneration should be excellent from the start. Contact Dept. 7 in care of the Journal. m9tfn

WANTED: GENERAL PRACTITIONER for associate with two other general practitioners in community of 2,400 with trade area of 7,000 in Green county. No investment required. Excellent clinical and diagnostic facilities. 200 bed hospital 15 miles. Good educational facilities. Convenient communications to recreational areas. Contact M. W. Stuessy, M.D., Brodhead. m3tfn

GENERAL PRACTICE available immediately in Milwaukee, Wis. (southeast side). Established 35 years, busy active practice, excellent location, beautiful ground floor clinic building, air-conditioned. Contact Dept. 41 in care of the Journal. m4tfn

GENERAL PRACTICE for sale in southeastern Wisconsin. Active practice of 13 years standing. For price of equipment and real estate. Air-conditioned first floor office, 1800 sq. ft. Supplementary rental income from three dental offices upstairs. City 3,500, drawing area 6,000. Open staff hospitals nearby. In fishing, hunting area. One hour away from State's largest cities for shopping, cultural activities. Contact Dept. 42 in care of the Journal. m4tfn

WANTED: OB–GYN physician and a general practitioner with some general surgical training to associate with another physician. Beautiful, large, new, well-equipped office. Parking lot. Air-conditioned. Starting salary $1,000. Partnership. City 10,000; drawing area 20,000. North Central Wisconsin. Contract Dept. 46 in care of the Journal. m4tfn

GOOD LOCATION AVAILABLE for general practitioner. Nothing to buy. Will assist and refer all general practice cases. Contact C. A. Sholtes, M.D., Richland Center, Wis., Midway 7–2592 or 7–2544. m9tfn

FOR SALE: GENERAL PRACTICE, well trained and active, in new fully equipped clinic building. Present physician leaving for residency. Personnel well trained and efficient. Rural village 38 miles northeast of Madison. New school, swimming pool, good housing available. Subsidy can be arranged through village. Contact Joseph G. Brown, M. D., Cambria, Wisconsin. m6tfn

FOR SALE: GENERAL PRACTICE in Chippewa Falls, Wis.; well established, same location for 17 years, fully equipped 5½-room office. Will take any reasonable offer and finance as you wish. Office help available. Practice available because of recent death of William F. Janc, M.D. Contact Mrs. William F. Janc, 300 Macomber Street, Chippewa Falls, Wis. m7tfn

MEDICAL SUITE: Thiensville–Mequon Medical Center Building, Thiensville, Wisconsin. Two doctors' offices, four examining rooms, lead lined x-ray room, laboratory, general office and waiting room. Heating and air conditioning furnished by owner. Available Nov. 1, 1963. Phone Chestnut 2–1080 or Chestnut 2–2344. E. C. Neidner, 231 South Main Street, Thiensville, Wisconsin. 5tfn

WANTED: GENERAL PRACTITIONER as associate in a four-man group with adequate clinical facilities. Offer open for two or three year locum tenens or for permanent association in the group. Town of 4,000, well-equipped 80-bed hospital, in west central Wisconsin. Contact Dept. 10 in care of the Journal. m9tfn

EENT SPECIALIST NEEDED for Eau Claire and vicinity, population 60,000. Could take over 20-year practice of deceased physician. Very advantageous opportunity. Contact Mrs. S. B. Russell, 114½ Grand Avenue West. Eau Claire, Wis. m3tfn

WANTED: USED EQUIPMENT of a physician. Young physician establishing private practice in Madison interested. Contact Dept. 34 in care of the Journal. m3tfn

GENERAL AND THORACIC SURGEON, Board certified, 36, American born, family, desires to practice in Wisconsin as associate, group, or solo. Contact Dept. 55 in care of the Journal. 5–6

WANTED: GENERAL PRACTITIONER or internist to take over immediately a large established practice on new northwest side of Milwaukee. Practice and office could accommodate two doctors if desired. New medical clinic building with all modern features includes private parking area, business office, large private office, four examining rooms, x-ray and laboratory facilities. Contact Dept. 56 in care of the Journal. m5tfn

GENERAL PRACTICE—Wisconsin—Established 9 years. Modern medical building to rent, 10 rooms, fully equipped including x-rays. Trained staff available. Two hospitals. Available June. Gross $40,000. Contact Dept. 54 in care of the Journal. 5–6

GROUP OF THREE desires general practitioner as associate. New clinic building with adequate facilities, in town of 5,500. Recent graduate preferable. Contact Plymouth Clinic, Plymouth, Wis. m4tfn

WANTED: Two young general practitioners to join 5-man group. Salary to start, early partnership western Wisconsin college town. Excellent hospital. Unlimited recreational facilities. Contact Dept. 50 in care of the Journal. 4–6

LOCATION WANTED: Either general practice or radiology or combination. Board eligible in radiology and experienced GP. Will serve several small hospitals in radiology, or will purchase retiring physician's equipment. Contact Dept. 51 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER, immediate full partnership in active practice now grossing $50,000, all advantages of dual practice with vacation periods and free weekends. No investment required. Full hospital privileges. Contact Dept. 53 in care of the Journal. m4tfn

ALLERGIST WANTED to share offices with dermatologist. Located in thriving area, south central Wisconsin. Unusual opportunity. Applicant must be board certified or qualified and intending to become certified. Reply, with details of personal and professional qualities and qualifications, to Dept. 5 in care of the Journal. m8tfn

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TWO INTERNISTS WANTED: Unusual opportunity to join a young multi-specialty group. Salary $18,000 first year with rapid acceleration to partnership. Exceptional clinic and hospital facilities in Midwest town of 30,000 which is the Medical Center of large trade area and a fine place to raise a family. Contact Dept. 44 in care of the Journal. 4–6

WANTED: INTERNIST for newly formed professional corporation in northeastern Wisconsin. Ideal living conditions and superior opportunity for advancement. Salary during first two years of association. Contact Dept. 25 in care of the Journal. 1tfn

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OUTSTANDING OPPORTUNITY for a young physician who is willing to work. Good schools, good 100-bed hospital. Good fishing and hunting. Retiring. Contact Dept. 32 in care of the Journal. m2–3tfn

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FOR RENT: OFFICE SPACE, 1200 sq. ft., for medical offices in modern, air-conditioned building at 16 East Gorham Street, Madison. Available for immediate occupancy. Will accommodate one or two physicians, preferably internists. Off-street parking. Contact Robin Allin, M.D., 1313 Fish Hatchery Road, Madison, Wis., phone ALpine 6–5521; or residence CEdar 3–2082. m8tfn

---

WANTED: PEDIATRICIAN for two-man department in 13-man multi-specialty group located in southern Wisconsin city of 37,000. Salary first two years, then share in profit. Excellent retirement and vacation policy. Contact Dept. 58 in care of the Journal. 6–11

WANTED: GENERAL PRACTITIONER or man with specialty who will do general practice and associate with one or two other men in well established practice. Fox River Valley. Immediate opening. Community of 50,000. Salary two years, then partnership. Contact Dept. 38 in care of the Journal. m4–5

WANTED: OPHTHALMOLOGIST for newly organized group in the Fox River Valley of Wisconsin. Community of over 50,000. Excellent living conditions, noted recreational area and above average opportunity. Salary two years then partnership. Contact Dept. 45 in care of the Journal. 4tfn

---

WANTED: GENERAL PRACTITIONER to join general practitioner in well established practice in southeastern Wisconsin. Town of 8,000. Class A accredited hospital. Salary or partnership if mutually agreeable. Contact Dept. 39 in care of the Journal. m3–5

URGENTLY NEEDED: General Practitioner to become associated with small clinic group in Milwaukee, Wis., preferably one who has had practical experience and a special interest in obstetrics or industrial surgery. First year, salary; then profit percentage leading to partnership. Contact Dept. 48 in care of the Journal. m4tfn

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WANTED: GENERAL PRACTITIONER. Must be graduate of class A medical school, preferably with two-year internship from class A teaching hospital. Midwest industrial city of 46,000. Open staffed, fully equipped, 250-bed hospital. Equal partnership if satisfactory within two years. Excellent recreational facilities. Have well established general practice. Contact Dept. 57 in care of the Journal. m5tfn

---

WANTED: Young, ambitious general practitioner needed at once at the Janesville Medical Center, 2020 E. Milwaukee St., Janesville, Wis. Salary for first year; and if mutually agreeable after one year, may become partner. Contact Duane F. Alexander, Business Manager. 3tfn

---

WANTED: GENERAL PRACTITIONER to replace retired physician in established three-man group. Must be interested in general medicine, obstetrics, and willing to assist in surgery. Fully equipped medical suite including x-ray and laboratory in town of 50,000 in Fox River Valley of Wisconsin. Unusual opportunity with eventual partnership. Contact Dept. 36 in care of the Journal. m3tfn

---

PHYSICIAN WANTED: General practitioner in northeastern Wisconsin wants part time help. Can use one man or combination to cover practice for week, month, or up to a year. Money no object for right man. No OB or surgery unless desired. Living facilities and car available. Contact Dept. 29 in care of the Journal. m1tfn

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FOR SALE: Genophthalmic chair, Genophthalmic refractor, Claison projector, eye glass display cabinet, treatment table, records from eye, ear, nose and throat practice—42 years. Price very reasonable. J. J. Sharpe, M.D., 150 E. First St., Fond du Lac; telephone 291 and 349. m3tfn

---

WANTED: PHYSICIAN to associate with two established general practitioners in southeastern Wisconsin industrial, agricultural community of 6,000. Prefer one who has had special surgical or obstetrical training and willing to do general practice along with surgery or obstetrics. Contact Dept. 31 in care of the Journal. m1–3tfn

---

HELP! Two-man practice with only one man! General practitioner. Small town. Salary first year; partnership later. T. S. Westcott, M.D., 115 West Chestnut St., Pardeeville, Wis. m3tfn

---

GENERAL PRACTITIONERS for psychiatric treatment center. Present salary range $10,896–$14,196 with possibility of legislative increase July 1, 1963. Excellent comprehensive fringe benefit program, 40-hour week and limited furnished housing for single physicians or small families available at nominal cost. Please contact W. J. Urben, M.D., Superintendent, Mendota State Hospital, 301 Troy Drive, Madison, Wis. g4tfn

---

GENERAL PRACTITIONER desires associate or partner. Liberal terms. No down payment. Two open staff hospitals. Plenty of work and plenty of recreational opportunities. A. B. Kores, M.D., Beaver Dam, Wis. m3tfn

---

PLAN FOR PSYCHIATRIC residency for July, 1964? NIMH General Practitioner program: $12,000 yearly, partially tax free. Three-year approved, balanced didactic and clinical training. In Michigan's Vacationland. Dr. Curtis W. Page, Training Director, Traverse City State Hospital, Traverse City, Michigan. 6–10

OFFICE FOR RENT: Wonderful location for a physician wanting to change or physician starting practice. Five-room office, heated, low rental (or possibly no rent at all to start; landlord anxious to help area obtain physician), newly remodeled, location in concentrated area with drawing population of 10,000. Has own shopping center. Two and one-half miles from downtown Milwaukee. Would be only physician in area which wants doctor very badly to take over practice of deceased physician who was there 26 years. Tremendous potential with cooperation of area businessmen and churches guaranteed. Contact Allen Pearson, Pearson Drugs, 501 N. 29th Street, Milwaukee, Wis.; or phone DIvision 4–5050. 6–8

WANTED: MEDICAL DIRECTOR for institution for the retarded. Specialty in pediatrics or internal medicine required. Staff of five physicians plus consultants in all specialties. Salary $18,672 to $21,672 depending on qualifications. Write: Mr. John M. Garstecki, Superintendent, Southern Colony and Training School, Union Grove, Wisconsin. g8tfn

INDEX TO ADVERTISERS

Ames Company, Inc. 47

Barr X-ray Co., The 29
Beutlich, Inc. 32
Borden's 34
Burroughs Wellcome & Co., Inc. 4, 39

Chatham Pharmaceuticals, Inc. 27
Coca Cola Company, The 42

Davies, Rose & Company, Ltd. 26

Endo Laboratories 35

Haug Drug Company 24
Hotel Schroeder 28
House of Bidwell, Inc. 29
Hurley X-ray Company 34

Keeley Institute, The 28

Lederle Laboratories 14, 15, 36
Lilly and Company, Eli ..... Front cover, 20

Medical Protective Company, The 16
Milwaukee Sanitarium Foundation 34

Parke, Davis & Company 2, 3
Physicians' Exchange 43, 44, 45
Poythress, Wm. P. & Co., Inc. 18

Rennebohm's 34
Robins Co., Inc., A. H. 6
Roche Laboratories ..... Back cover
Rogers Memorial Hospital 16

Sacred Heart Sanitarium 46
St. Croixdale Sanitarium 4
St. Mary's Hill Hospital 42
Sanborn Company 13
Saunders Company, W. B. 9
Schering Corporation 19
Searle & Co., G. D. 21
Shorewood Sanitarium 29
Smith Kline & French Laboratories 17

Time Insurance Company 28

Wallace Laboratories 10, 11, 22, 23, 33, 41
Winthrop Laboratories 12, 38, 40
Wisconsin Physicians Service 30

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William H. McCreary, Jr., M. D.
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the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

CONTENTS

VOL. 62, No. 7 JULY 1963

Special issue honoring Marquette University School of Medicine Fiftieth Anniversary

Cover: Marquette's Colors—Blue and Gold

SCIENTIFIC ARTICLES

Bacterial Endocarditis and Endarteritis Following Cardiac Operations, by Joseph E. Geraci, M.D., Allan J. D. Dale, M.D., and Dwight C. McGoon, M.D., Rochester, Minnesota ---------- 302

Laboratory Diagnosis of Collagen Diseases, by Frank J. Glassy, M.D., Sacramento, California ---------- 316

SPECIAL ARTICLES

A Half Century of Service, by John S. Hirschboeck, M.D., Milwaukee ---------- 293

A Salute to 50 Years of Progress, by Edward R. Annis, M.D., Miami, Florida ---------- 294

Marquette University School of Medicine—The First Fifty Years, by Walter Zeit, Ph.D., Milwaukee ---------- 295

Detergents in Wisconsin Surface Waters --- 315

Comments on Treatment: Oral Hyperglycemic Agents, by Deane N. Calvert, Ph.D., Milwaukee ---------- 324

Physicians, Then and Now ---------- 328

EDITORIALS

President's Page: Significant Meetings, by E. J. Egan, M.D., Milwaukee ---------- 326

A Remedy ---------- 327

REGULAR FEATURES

Letters ---------- 7

News of Wisconsin Physicians ---------- 27

Facts about Wisconsin Physicians Service -- 33

Medical Meetings ---------- 35

Physicians Exchange ---------- 43

Index to Advertisers ---------- 46

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Journal
Established 1903

Annual Subscription--------$6.00
Single Copy---------- 1.00
Previous Years'---------- 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 303 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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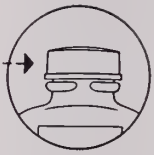

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LETTERS

SPARTEINE—WORDS OF CAUTION

To WMJ:

The review of sparteine in the April issue of the *Wisconsin Medical Journal* by Dr. A. C. Yard should not go unchallenged. Essentially his article is a review of two papers by M. J. Gray and A. C. Plentl in 1958 and 1961. The greatest danger in this article are the statements implying that sparteine can be used without moment to moment control. Doctor Yard implies this in the following quotation. "These difficulties (uterine tetany) have not been reported in the literature dealing with the clinical use of sparteine, thus making it unnecessary to provide moment to moment control over the dosage offered by an intravenous infusion. Sparteine can be administered intramuscularly and the patient receiving it need not be the object of continuous supervision." A second quotation further implies the safety of this drug. "—And no report of tetanic contraction of the uterus has occurred to date, nor has there been any suggestion that sparteine influences the incidence of maternal or fetal complications." These statements are dangerous for two reasons. First of all, sparteine is an oxytocic and must be given according to state law under direct supervision of the physician. Secondly, I believe that with more experience these statements have been proven to be untrue. In the April *Obstetrics and Gynecology*, there are two articles dealing with complications due to the administration of sparteine. The first one is entitled "Uterine Tetany and Fetal Distress, Coincidental with the Administration of Sparteine" by Dr. L. Bedrosian and the second article in the same journal is entitled "Sparteine Sulfate and Rupture of the Uterus" by Dr. Harry Boyson.

I should like to add that since these articles have been published, the pharmaceutical house which makes sparteine has sent out literature stating the contra-indications to sparteine and the contra-indications and hazards are essentially the same as those of Pitocin or any other oxytocic.

The appeal for this particular drug is obvious. It was advertised originally as a safe agent for inducing labor and for overcoming uterine dysfunction and it was implied that this was a very safe drug and did not require constant supervision by the M.D. This, therefore, would be much easier for a physician to use, than an infusion of Pitocin which requires minute to minute attention and constant attendance by the M.D. This drug, however, is less predictable as an oxytocic agent and certainly does not have the safety factor which dilute intravenous Pitocin has when used before completion of the second stage of labor. Clinically many of us in Milwaukee have used this drug and although I think there have been no fetal or maternal deaths directly attributable to this agent in the State of Wisconsin, I do know of several reports of tetanic contractions of the uterus and of fetal distress associated with its use. Recently, I had the opportunity of speaking with Dr. David Danforth, in Chicago and he knows of several cases of ruptured uterus which occurred in that metropolitan area due to the use of sparteine.

From what I have said, perhaps one would conclude that I believe this drug should be discarded. This is not true. However, this drug must be treated with a great deal of respect and if it is used, it should be used under constant supervision of the physician.

John R. Evrard, M.D., *Chairman*,
Division of Maternal and Child Welfare,
State Medical Society

HE LIKED THE PROGRAM

To SMS:

The meeting in Kenosha was terrific. Thank you for arranging it.

O. H. Hanson, M.D.
Fort Atkinson

(Editor's Note: The meeting referred to above was a Maternal Mortality Institute sponsored by the State Medical Society's CES Foundation.)

SUMMER TOURNAMENT—WISCONSIN STATE MEDICAL GOLF ASSOCIATION

The Annual Summer Tournament of the Wisconsin State Medical Golf Association will be held August 20th at the Branch River Country Club in Manitowoc. An expected turnout of 150 golfers will participate for trophies to be presented for scores of Low Gross and Low Net. Once again the Senior Event trophy will be awarded to that member over the age of 50 attaining the lowest gross. In addition to trophy awards, prizes will be given for closest to the pin and for the longest drives on designated holes. Runners-up on each trophy event will also receive a prize award. All remaining prizes will be distributed during the dinner program.

The annual meeting for election of officers for next year will be conducted at the conclusion of dinner and awarding of prizes. A charge of $12.00 for golf and dinner will be made. All reservations and checks may be sent to the Wisconsin State Medical Golf Association, 756 North Milwaukee Street, Milwaukee 2, Wisconsin.

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NEWS OF WISCONSIN PHYSICIANS

Doctor Simenstad Honored

Dr. L. O. Simenstad, Osceola, was elected to the Board of Trustees of the American Medical Association at its 112th annual meeting held June 16–20 at Atlantic City, N. J. The term is for two years and is one of three new posts on the Board created by the AMA House of Delegates at this meeting.

Active in AMA affairs since 1943, Doctor Simenstad has previously served as a member of committees on military medical affairs and aviation medicine. At the time of his election he was a member of the AMA council on national security and a delegate from Wisconsin.

He has held numerous offices in medical organizations including the presidency of both the State Medical Society of Wisconsin and the North Central Conference. An expert pilot, Doctor Simenstad is former chairman of the Wisconsin Aeronautics Commission and is currently a member of the medical advisory panel of the Federal Aviation Agency.

In addition to his state and national activities in medicine, he has served as mayor of Osceola for more than 20 years.

Doctor Stovall Reelected at AMA

Dr. W. D. Stovall, Madison, was reelected to the Council on Constitution and Bylaws of the AMA at its annual meeting in Atlantic City, N. J., June 16–20. Doctor Stovall has been active in AMA affairs for many years and is recognized as a great medical statesman.

Opens Anesthesia Practice

Dr. Joanna R. Miller has announced the opening of a practice limited to anesthesia in Kenosha.

Sacred Heart Sanitarium Head Retires

Dr. William L. Herner, Milwaukee, who completed 50 years of service at Sacred Heart Sanitarium, and 31 years as medical director, retired May 1. *Dr. John F. Wyman,* a member of the medical staff of the Sanitarium for 33 years, has been appointed to succeed Doctor Herner as medical director.

Doctor Palermo Certified in Psychiatry

Dr. George B. Palermo, Milwaukee, was recently certified by the American Board of Psychiatry and Neurology, in psychiatry.

To Honor Dutch Medical Educator

A Wisconsin physician was one of 35 American surgeons who repaid a professional debt to a world-renowned Dutch medical educator of the early 18th century when they presented a postgraduate course in nasal surgery at the University of Leiden, the Netherlands. *Dr. Irwin E. Gaynon,* Milwaukee, served as one of the instructors to nasal surgery specialists who came from every continent of the world for the course which was given July 14–27 at the University Hospital in the Boerhaave Center. The group made the journey under the auspices of the American Rhinologic Society.

Physicians Speak to Janesville Rotarians

Six physicians gave their comments on "what is new in medicine" at a meeting of the Janesville Rotarians. The doctors were *Everett W. Reinardy, Richard S. Overton, Samuel A. Freitag, Paul K. Odland, Ernesto F. Sabado,* and *Katsumi Neeno. Dr. Marshall F. Purdy* arranged the program.

Psychiatrist Speaks on Mental Health

Dr. C. F. Midelfort, La Crosse, psychiatrist, recently spoke on "Mental Health, Religion and the Family" at the Orchard Ridge United Church of Christ in Madison. He is an internist and neurologist as well, and is chairman of the committee on basic ideas underlying religion and health for the National Council of Churches.

Dr. Kindwall is PTA Speaker

Dr. Joseph Kindwall, psychiatrist and consultant at Rogers Memorial Hospital, was a guest speaker at the Okauchee School PTA in Oconomowoc recently.

Dr. R. W. Edland Promoted to Major

Dr. Robert W. Edland, Madison, has recently been promoted to major while serving with the U.S. Army in Augsburg, Germany. He presently is head of the radiology department of the Army's 12th and 21st Field Hospitals. He also has recently been named recipient of a fellowship for further study in radiotherapy at Walter Reed hospital, Washington, D.C. He and his wife will return to the United States in June. Doctor Edland is a graduate of the University of Wisconsin Medical School.

Physicians whose names appear in italic are members of the State Medical Society.

Dr. William Hildebrand Speaks

Dr. William B. Hildebrand, Menasha, spoke at a public gathering during the Heart Fund Drive. He is a member of the advisory committee on fund raising and public policy of the American Heart Association.

Discusses Japanese Art

Members of the Marshfield Woman's Club heard *Dr. Bahij S. Salibi* discuss Japanese art at a recent meeting. The doctor is a neurosurgeon at the Marshfield Clinic.

Doctor Discusses Sex Education

For "public schools to integrate sex education right from the beginning (kindergarten)" would be best, *Dr. William P. Wendt* told a Menomonee Falls PTA gathering earlier this year. Doctor Wendt is a gynecologist and obstetrician in Milwaukee.

Medical Assistants Hear Dr. Link

Dr. Darrell Link, Beaver Dam, discussed diabetes at a meeting of the Dodge County Medical Assistants Society.

Addresses Group on Medical Care

Dr. Robin N. Allin, Madison, addressed a group of Janesville women on the subject of Medical Care for 65 Plus at a public meeting this spring sponsored by the Janesville Republican Women's Club.

Spooner Physician Attends Course

Dr. Lester J. Olson, Spooner, attended a four-day course in trauma and acute injuries at the Mayo Clinic in Rochester this spring. Doctor Olson was one of 46 physicians who attended.

Dr. Elaine Thomas Opens Office

Dr. Elaine Thomas, chairman of the pediatric section of the medical staff of St. Luke's hospital, Milwaukee, opened an office in New Berlin in February. She is a graduate of the University of Chicago and is currently a clinical instructor in pediatrics at Marquette University School of Medicine.

Dr. H. F. Borenz Speaks

Dr. Harold F. Borenz, child psychiatrist at the University of Wisconsin Medical Center, spoke on "What is an Emotionally Disturbed Child" at the annual convention of the Southern Wisconsin Education Association at the Wisconsin Center earlier this year.

Facts about

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1963 **Wisconsin**

Oct. 20–23: Annual District VI meeting of American College of Obstetricians and Gynecologists, Milwaukee.

Nov. 21: Eberbach Memorial lecture honoring Milwaukee Hospital centennial, by Dr. Carl E. Badgley, professor of orthopedic surgery, University of Michigan School of Medicine, Milwaukee.

1963 **Out-of-State**

Aug. 5–9: Postgraduate course on Pediatrics, University of Colorado Medical Center, Estes Park.

Aug. 19–23: Medical Audiology Workshop, University of Colorado Medical Center, Denver.

Aug. 21–23: Regional seminar for American Medical Examiners, University of Minnesota.

Aug. 26: Annual meeting of American Academy of Physical Medicine and Rehabilitation, Sheraton–Dallas Hotel, Dallas, Tex.

Sept. 15–21: International Congress on Occupational Health, Madrid, Spain.

Sept. 16–28: Course in Laryngology and Bronchoesophagology, University of Illinois College of Medicine, Chicago.

Sept. 16–20: Pulmonary Disease Seminar, University of Colorado Medical Center, Fitzsimons General Hospital, Denver.

Sept. 25–26: National Congress on Occupational Health, sponsored by the AMA's Council on OH, San Francisco.

Oct. 12–13: Annual meeting, The Mid West Allergy Forum, Sheraton-Cleveland Hotel, Public Square, Cleveland, Ohio.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, sponsored by the Council on International Affairs of the American College of Chest Physicians, Mexico City.

Oct. 13–19: XVIIth World Medical Assembly (originally scheduled in Mexico City Sept. 22–28), Commodore Hotel, New York City.

Oct. 14–18: Course in Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, International Inn, Washington D. C., American College of Chest Physicians.

Oct. 14–18: Course in Sources and Use of Toxicological Information, Institute of Industrial Medicine, New York University Medical Center, Onchiota Conference Center, Tuxedo, N.Y.

Oct. 16–19: Conference on Obstetric, Gynecologic and Neonatal Nursing, sponsored by District VI, American College of Obstetricians and Gynecologists, Chicago.

Oct. 21–22: 1963 Scientific Session of American Cancer Society—A conference on "Unusual Forms and Aspects of Cancer in Man", Biltmore Hotel, New York City.

Oct. 21–24: Interstate Postgraduate Medical Assembly, scientific program, Chicago.

Oct. 21–25: Course in Clinical Cardiopulmonary Physiology, American College of Chest Physicians, Pick Congress Hotel, Chicago.

Oct. 23–25: Chiefs-of-staff Conference, University of Colorado Medical Center, Denver.

Oct. 24–26: Course in Postgraduate Gastroenterology, American College of Gastroenterology, Washington, D. C.

Oct. 25–26: Second National Congress on Medical Quackery, Sheraton–Park Hotel, Washington, D. C.

Oct. 25–27: Annual scientific sessions of the American Heart Association Biltmore Hotel, Los Angeles, Calif.

Oct. 27–Nov. 1: Annual clinical congress, American College of Surgeons, Chicago, Ill.

Nov. 5–13: Ninth Congress of the Pan–Pacific Surgical Association, Honolulu, Hawaii.

Nov. 11–15: Course in Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Barbizon Plaza Hotel, New York City.

Nov. 13–Dec. 10: First Pan–Pacific Mobile Educational Lecture Seminar, New Zealand, Australia, Thailand, the Philippines, Hong Kong and Japan.

Nov. 18–21: Annual meeting of the Southern Medical Association, New Orleans, La.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Nov. 22–25: Annual convention, National Society for Crippled Children and Adults, Palmer House, Chicago.

Nov. 23: Annual meeting, American Rhinologic Society, Illinois Masonic Hospital, Chicago.

Dec. 2–6: Course in Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Ambassador Hotel, Los Angeles.

1964

Jan. 13–17: Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Hotel Fontainebleau, Miami Beach.

May 11–14: Annual scientific meeting, Aerospace Medical Association, Americana Hotel, Bal Harbour, Miami, Fla.

May 25–27: Annual meeting, American Thoracic Society, medical section of the National Tuberculosis Association, New York City.

Pan–Pacific Surgical Association

The Ninth Congress of the Pan–Pacific Surgical Association is scheduled for November 5–13, 1963, in Honolulu, Hawaii, and the First Pan–Pacific Mobile Educational Lecture Seminar is planned for November 13–December 10, 1963, in New Zealand, Australia, Thailand, the Philippines, Hong Kong, and Japan.

The Ninth Congress will offer an extensive scientific program of 300 leading surgeons in nine surgical specialties. The Seminar through the Pacific area will offer scientific meetings in each country presenting medical material unique to the areas.

For further information, write Dr. F. J. Pinkerton, Director General, Pan–Pacific Surgical Association, Suite 236, Alexander County Building, Honolulu 13, Hawaii.

Midwest Allergy Forum

The annual meeting of the Midwest Allergy Forum will be held at the Sheraton–Cleveland Hotel, Public Square, Cleveland, Ohio, October 12 and 13. The one and one-half days of scientific sessions will include panels on chronic pulmonary problems, cutaneous diseases, repository methods of therapy, and many other problems of clinical allergy.

For further information write to: I. M. Hinnant, M.D., General Chairman, 10465 Carnegie Avenue, Cleveland 6, Ohio.

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Classified Advertisements

Advertisements in this section are accepted in two categories: PHYSICIANS' EXCHANGE and COMMERCIAL.

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DEADLINE: Copy must be received by the 15th of the month preceding month of issue. Send copy to: Wisconsin Medical Journal, Box 1109, Madison 1, Wis.; or phone Alpine 6–3101.

PHYSICIANS' EXCHANGE: This section is limited to physicians and others desiring physician placement, sale of medical practice or equipment of a physician, sale or lease of medical buildings, etc. Advertisements from individual members of the State Medical Society of Wisconsin are accepted without charge. Widows of deceased member physicians are allowed to advertise without charge. The rates quoted above apply to ads placed by clinics and others. There is no additional charge for ads with Dept. numbers. For these ads, address replies to: Dept. ___, % Wisconsin Medical Journal, Box 1109, Madison 1, Wis. Advertisers using Dept. numbers forbid the disclosure of their identity. All inquiries are forwarded to them immediately.

COMMERCIAL: Advertisements are accepted at the above rates from individuals, firms, organizations, etc., who are reputable, have a good credit rating and advertise products or services of ethical standards. The Journal reserves the right to reject any advertising. Advertisements from member physicians are also accepted at the above rates.

PHYSICIANS' EXCHANGE

WANTED: INTERNISTS—GENERAL PRACTITIONERS in college health service at the University of Wisconsin. Excellent opportunity. Possibilities of academic appointment. Salary $11,000–$15,000, dependent on qualifications. Contact Peter L. Eichman, M.D., Director of Student Health, University of Wisconsin, 1300 University Avenue, Madison 6, Wisconsin. g6tfn

WANTED by certified psychiatrist, association with a group, GP, or internist, in or within 40 miles of Milwaukee area. Contact Dept. 62 in care of the Journal. 7

FOR SALE: UNOPPOSED small town general practice, southwestern Wisconsin. Modern, well equipped, air conditioned building, excellent open staff hospital nearby. Annual gross over $50,000. Contact Dept. 999 in care of the Journal. m8tfn

WANTED: Certified or qualified specialist in—

1. Psychiatry
2. Neurology
3. Plastic Surgeon
4. Pathology
5. Anesthesiology
6. Ophthalmology
7. Proctology

also Registered Pharmacist and EEG Technician to join 28-man, all-specialist group. Contact Harold E. Scherer or Robert G. Zach, M.D., The Monroe Clinic, Monroe, Wis. 4tfn

FOR SALE: Established EENT practice, over 40 years in the heart of Milwaukee. Excellent referrals; will introduce; retiring. Contact Dept. 24 care of the Journal. m12tfn

OFFICE SPACE for two or three physicians, OB or two surgeons. To rent or to sell. Pharmacy in same building. Contact Dept. 33 in care of the Journal. m3tfn

WANTED: GENERAL PRACTITIONER as associate. Immediately available opportunity to practice in well established group of two. Replacement for sudden loss of partner. Eventual partnership. 126 E. Main Street, Madison. AL 6–3171. m9tfn

EXCEPTIONAL OPPORTUNITY for physician at Siren, Wis. (Burnett County). Present physician entering specialty, but will assist in introducing prior to September. No financial outlay needed. Progressive and economical community. Extensive general practice with OB and surgery of all grades. May require more than one physician. In heart of fishing and hunting area. Community willing to go all out for right person. Contact G. A. Grindell, M.D., Siren Memorial Hospital, phone 715–349–2380. 7

WANTED: GENERAL PRACTITIONER as a replacement in town of 1,275 in southern Wisconsin. Gross receipts $42,000 in 1961, over $24,000 first 6 months 1962. Unopposed, good schools, churches, roads, fishing. Nearby accredited 200 bed hospital. Leaving for residency. Contact: D. L. Minter, M.D., Clinton, Wis. m9tfn

WANTED: PSYCHIATRISTS or young doctors, interested in psychiatry to work at Mendota State Hospital. These positions are permanent and under Civil Service; salary depends upon previous experience and training. Housing available on grounds. Contact W. J. Urben, M.D., Superintendent, Madison 4, Wis. g10tfn

FOR SALE: Two level home and office on bank of river; 45-acre estate near town of 6,000, 70 miles north of Madison. Hospital, good schools, several churches. Man with surgical training desirable. Purchase may be made by land contract. Might consider a locum tenens with potential permanent arrangement. A highly flexible opportunity for the right person. Contact Dept. 23 in care of the Journal. m12tfn

WANTED: INTERNIST, Board certified, to join two established surgeons. Excellent office facilities. Opposite 300-bed hospital—200-bed added expansion in progress. Town of 15,000. Central Wisconsin. Guaranteed salary. Percentage and partnership early prospects. Contact Paul F. Doege Medical Center, 512 St. Joseph Ave., Marshfield, Wis. m3tfm

WANTED: GENERAL PRACTITIONER for association with two-man group located near Madison. Excellent hospital and recreational facilities. Salary open to start with partnership opportunity at end of one year. New building with excellent equipment and personnel. Contact Dept. 52 in care of the Journal. m4tfn

PHYSICIANS, with or without pediatric training, needed in maternal and child health program at salaries ranging from $9,960.00 to $13,200.00. Five-day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, Milwaukee Health Department, Municipal Building, Milwaukee 2, Wis. g8tfn

GENERAL PRACTICE FOR SALE. Physician desiring own x-ray equipment may purchase radiographic, fluoroscopic and therapy equipment. Seven-room office on main corner in southern Wisconsin city of 35,000 occupied for over 40 years. Wish to retire. Reasonable price. Contact Dept. 19 in care of the Journal. m11tfn

PARTNER IN GENERAL PRACTICE WANTED in Green Lake county, town of 5,000. Fifty-bed private hospital. Five grade schools and one high school. No predominant nationalities. Various churches. Main occupations are leather, fur and metal. Contact Dept. 20 in care of the Journal. m11tfn

WANTED: PHYSICIAN with military service fulfilled to associate with a general surgeon also in general practice in northeastern Wisconsin in a city of 75,000. Excellent salary leading to early partnership. This is an A-1 financial opportunity. An early interview is appreciated. Contact Dept. 43 in care of the Journal. m4tfn

URGENTLY NEEDED: Associate going for residency—another man urgently needed. Twelve miles east of Fond du Lac, Catholic rural area. Start at $1,300 or more monthly. No investment. Available June. Contact Jos. F. Miller, M.D., Mt. Calvary, Wis. m4tfn

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WANTED: INTERNIST, Board certified or eligible for association with young internist in southeastern Wisconsin city of 90,000. Contact Dept. 980 in care of the Journal. m4tfn

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FOR SALE: IN WISCONSIN. General practice, well established, same location 40 years, fully equipped 7-room office. Will take any reasonable offer and finance as you wish. Poor health forces retirement. Contact Dept. 912 in care of the Journal. m4tfn

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WANTED: PHYSICIAN to share a clinic which is now occupied by an M.D. and a D.D.S., located in a prosperous southeastern Wisconsin industrial and farming community where the need for another physician is very great. Contact Dept. 827 in care of the Journal. 4tfn

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FOR SALE: PEDIATRICS PRACTICE in suburb of large Wisconsin city; will introduce; buyer assume two-year lease; open hospital staff; physician leaving Sept. 1, 1962, for academic post. Contact Dept. 985 in care of the Journal. m5tfn

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WANTED: GENERAL PRACTITIONER to become associated with small group in central Wisconsin, preferably one who has had some practical experience, and has a special interest in obstetrics; also willing to only assist in surgery. Contact Dept. 969 in care of the Journal. m2tfn

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OFFICE SPACE in medical clinic, 2218 North Third Street, Milwaukee, Wis.; Co. 4–2800. m3tfn

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WANTED: GENERAL PRACTITIONER to replace physician who left for residency training. Fully equipped office available immediately. Town of 2,100 offers good hospital, skiing, hunting, golf, fishing and many other recreational advantages along the Chippewa River near its junction with the Mississippi. Financial remuneration should be excellent from the start. Contact Dept. 7 in care of the Journal. m9tfn

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WANTED: GENERAL PRACTITIONER for associate with two other general practitioners in community of 2,400 with trade area of 7,000 in Green county. No investment required. Excellent clinical and diagnostic facilities. 200 bed hospital 15 miles. Good educational facilities. Convenient communications to recreational areas. Contact M. W. Stuessy, M.D., Brodhead. m3tfn

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GENERAL PRACTICE available immediately in Milwaukee, Wis. (southeast side). Established 35 years, busy active practice, excellent location, beautiful ground floor clinic building, air-conditioned. Contact Dept. 41 in care of the Journal. m4tfn

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WANTED: GENERAL PRACTITIONER. Must be graduate of class A medical school, preferably with two-year internship from class A teaching hospital. Midwest industrial city of 46,000. Open staffed, fully equipped, 250-bed hospital. Equal partnership if satisfactory within two years. Excellent recreational facilities. Have well established general practice. Contact Dept. 57 in care of the Journal. m5tfn

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WANTED: OB–GYN physician and a general practitioner with some general surgical training to associate with another physician. Beautiful, large, new, well-equipped office. Parking lot. Air-conditioned. Starting salary $1,000. Partnership. City 10,000; drawing area 20,000. North Central Wisconsin. Contract Dept. 46 in care of the Journal. m4tfn

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WANTED: GENERAL SURGEON, well qualified, to join two man clinic group in community of 40,000. Excellent facilities and limitless opportunity. State qualifications and availability when contacting Dept. 61 in care of the Journal. m7tfn

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FOR SALE: American Sterilizer Company autoclave, interior dimensions 8" x 8" x 15½", model 548A. Val V. Quandt, M.D., 57 South Main Street, Hartford, Wis. m7tfn

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GOOD LOCATION AVAILABLE for general practitioner. Nothing to buy. Will assist and refer all general practice cases. Contact C. A. Sholtes, M.D., Richland Center, Wis., Midway 7–2592 or 7–2544. m9tfn

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FOR SALE: GENERAL PRACTICE, well trained and active, in new fully equipped clinic building. Present physician leaving for residency. Personnel well trained and efficient. Rural village 38 miles northeast of Madison. New school, swimming pool, good housing available. Subsidy can be arranged through village. Contact Joseph G. Brown, M. D., Cambria, Wisconsin. m6tfn

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FOR SALE: GENERAL PRACTICE in Chippewa Falls, Wis.; well established, same location for 17 years, fully equipped 5½-room office. Will take any reasonable offer and finance as you wish. Office help available. Practice available because of recent death of William F. Janc, M.D. Contact Mrs. William F. Janc, 300 Macomber Street, Chippewa Falls, Wis. m7tfn

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MEDICAL SUITE: Thiensville–Mequon Medical Center Building, Thiensville, Wisconsin. Two doctors' offices, four examining rooms, lead lined x-ray room, laboratory, general office and waiting room. Heating and air conditioning furnished by owner. Available Nov. 1, 1963. Phone Chestnut 2–1080 or Chestnut 2–2344. E. C. Neidner, 231 South Main Street, Thiensville, Wisconsin. 5tfn

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WANTED: GENERAL PRACTITIONER as associate in a four-man group with adequate clinical facilities. Offer open for two or three year locum tenens or for permanent association in the group. Town of 4,000, well-equipped 80-bed hospital, in west central Wisconsin. Contact Dept. 10 in care of the Journal. m9tfn

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EENT SPECIALIST NEEDED for Eau Claire and vicinity, population 60,000. Could take over 20-year practice of deceased physician. Very advantageous opportunity. Contact Mrs. S. B. Russell, 114½ Grand Avenue West, Eau Claire, Wis. m3tfn

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WANTED: USED EQUIPMENT of a physician. Young physician establishing private practice in Madison interested. Contact Dept. 34 in care of the Journal. m3tfn

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WANTED: GENERAL PRACTITIONER or internist to take over immediately a large established practice on new northwest side of Milwaukee. Practice and office could accommodate two doctors if desired. New medical clinic building with all modern features includes private parking area, business office, large private office, four examining rooms, x-ray and laboratory facilities. Contact Dept. 56 in care of the Journal. m5tfn

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GROUP OF THREE desires general practitioner as associate. New clinic building with adequate facilities, in town of 5,500. Recent graduate preferable. Contact Plymouth Clinic, Plymouth, Wis. m4tfn

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LOCATION WANTED: Either general practice or radiology or combination. Board eligible in radiology and experienced GP. Will serve several small hospitals in radiology, or will purchase retiring physician's equipment. Contact Dept. 51 in care of the Journal. m4tfn

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WANTED: GENERAL PRACTITIONER, immediate full partnership in active practice now grossing $50,000, all advantages of dual practice with vacation periods and free weekends. No investment required. Full hospital privileges. Contact Dept. 53 in care of the Journal. m4tfn

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WANTED: A two man partnership would like a general practitioner interested in internal medicine or an internal medicine man to become associated. Location is in north central Wisconsin. New hospital facilities are available as well as a large extensively equipped office. Contact Dept. 59 in care of the Journal. m7tfn

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WANTED: Young physician interested in work in medical institution, practicing high degree of internal medicine, psychiatry, and neurology. Excellent salary. Splendid working conditions. Fully accredited 220 bed facility. Contact Dept. 60 in care of the Journal. 7

ALLERGIST WANTED to share offices with dermatologist. Located in thriving area, south central Wisconsin. Unusual opportunity. Applicant must be board certified or qualified and intending to become certified. Reply, with details of personal and professional qualities and qualifications, to Dept. 5 in care of the Journal. m8tfn

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WANTED: INTERNIST for newly formed professional corporation in northeastern Wisconsin. Ideal living conditions and superior opportunity for advancement. Salary during first two years of association. Contact Dept. 25 in care of the Journal. 1tfn

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OUTSTANDING OPPORTUNITY for a young physician who is willing to work. Good schools, good 100-bed hospital. Good fishing and hunting. Retiring. Contact Dept. 32 in care of the Journal. m7–9

FOR RENT: OFFICE SPACE, 1200 sq. ft., for medical offices in modern, air-conditioned building at 16 East Gorham Street, Madison. Available for immediate occupancy. Will accommodate one or two physicians, preferably internists. Off-street parking. Contact Robin Allin, M.D., 1313 Fish Hatchery Road, Madison, Wis., phone ALpine 6–5521; or residence CEdar 3–2082. m8tfn

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WANTED: PEDIATRICIAN for two-man department in 13-man multi-specialty group located in southern Wisconsin city of 37,000. Salary first two years, then share in profit. Excellent retirement and vacation policy. Contact Dept. 58 in care of the Journal. 6–11

WANTED: GENERAL PRACTITIONER or man with specialty who will do general practice and associate with one or two other men in well established practice. Fox River Valley. Immediate opening. Community of 50,000. Salary two years, then partnership. Contact Dept. 38 in care of the Journal. m4–5

WANTED: OPHTHALMOLOGIST for newly organized group in the Fox River Valley of Wisconsin. Community of over 50,000. Excellent living conditions, noted recreational area and above average opportunity. Salary two years then partnership. Contact Dept. 45 in care of the Journal. 4tfn

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WANTED: GENERAL PRACTITIONER to join general practitioner in well established practice in southeastern Wisconsin. Town of 8,000. Class A accredited hospital. Salary or partnership if mutually agreeable. Contact Dept. 39 in care of the Journal. m3–5

URGENTLY NEEDED: General Practitioner to become associated with small clinic group in Milwaukee, Wis., preferably one who has had practical experience and a special interest in obstetrics or industrial surgery. First year, salary; then profit percentage leading to partnership. Contact Dept. 48 in care of the Journal. m4tfn

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WANTED: Young, ambitious general practitioner needed at once at the Janesville Medical Center, 2020 E. Milwaukee St., Janesville, Wis. Salary for first year; and if mutually agreeable after one year, may become partner. Contact Duane F. Alexander, Business Manager. 3tfn

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WANTED: GENERAL PRACTITIONER to replace retired physician in established three-man group. Must be interested in general medicine, obstetrics, and willing to assist in surgery. Fully equipped medical suite including x-ray and laboratory in town of 50,000 in Fox River Valley of Wisconsin. Unusual opportunity with eventual partnership. Contact Dept. 36 in care of the Journal. m3tfn

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PHYSICIAN WANTED: General practitioner in northeastern Wisconsin wants part time help. Can use one man or combination to cover practice for week, month, or up to a year. Money no object for right man. No OB or surgery unless desired. Living facilities and car available. Contact Dept. 29 in care of the Journal. m1tfn

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FOR SALE: Genophthalmic chair, Genophthalmic refractor, Claison projector, eye glass display cabinet, treatment table, records from eye, ear, nose and throat practice—42 years. Price very reasonable. J. J. Sharpe, M.D., 150 E. First St., Fond du Lac; telephone 291 and 349. m3tfn

---

WANTED: PHYSICIAN to associate with two established general practitioners in southeastern Wisconsin industrial, agricultural community of 6,000. Prefer one who has had special surgical or obstetrical training and willing to do general practice along with surgery or obstetrics. Contact Dept. 31 in care of the Journal. m1–3tfn

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HELP! Two-man practice with only one man! General practitioner. Small town. Salary first year; partnership later. T. S. Westcott, M.D., 115 West Chestnut St., Pardeeville, Wis. m3tfn

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GENERAL PRACTITIONERS for psychiatric treatment center. Present salary range $10,896–$14,196 with possibility of legislative increase July 1, 1963. Excellent comprehensive fringe benefit program, 40-hour week and limited furnished housing for single physicians or small families available at nominal cost. Please contact W. J. Urben, M.D., Superintendent, Mendota State Hospital, 301 Troy Drive, Madison, Wis. g4tfn

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GENERAL PRACTITIONER desires associate or partner. Liberal terms. No down payment. Two open staff hospitals. Plenty of work and plenty of recreational opportunities. A. B. Kores, M.D., Beaver Dam, Wis. m3tfn

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PLAN FOR PSYCHIATRIC residency for July, 1964? NIMH General Practitioner program: $12,000 yearly, partially tax free. Three-year approved, balanced didactic and clinical training. In Michigan's Vacationland. Dr. Curtis W. Page, Training Director, Traverse City State Hospital, Traverse City, Michigan. 6–10

OFFICE FOR RENT: Wonderful location for a physician wanting to change or physician starting practice. Five-room office, heated, low rental (or possibly no rent at all to start; landlord anxious to help area obtain physician), newly remodeled, location in concentrated area with drawing population of 10,000. Has own shopping center. Two and one-half miles from downtown Milwaukee. Would be only physician in area which wants doctor very badly to take over practice of deceased physician who was there 26 years. Tremendous potential with cooperation of area businessmen and churches guaranteed. Contact Allen Pearson, Pearson Drugs, 501 N. 29th Street, Milwaukee, Wis.; or phone DIvision 4–5050. 6–8

WANTED: MEDICAL DIRECTOR for institution for the retarded. Specialty in pediatrics or internal medicine required. Staff of five physicians plus consultants in all specialties. Salary $18,672 to $21,672 depending on qualifications. Write: Mr. John M. Garstecki, Superintendent, Southern Colony and Training School, Union Grove, Wisconsin. g8tfn

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ASSOCIATE WANTED in general practice. $18,000 guaranteed clear per year. Should earn $30,000 clear after two years. Contact Jos. F. Miller, M.D., Mt. Calvary, Wis. m7tfn

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WELL ESTABLISHED 6 man group in Iowa town of 6,300 needs board eligible or certified internist immediately. Community building a new hospital. Salary first year, then percentage of net. Salary open. Contact Dept. 63 in care of the Journal. 7–8

FOR SALE: Air-conditioned first floor office building, 1800 sq. ft., supplemental rental income from three dental offices upstairs. Owner in practice 13 years before leaving, had large, active practice. In city of Mayville, Wis., near Horicon marsh recreational area, state's largest cities for cultural, shopping activities. Open staff hospitals nearby. Contact Mr. Earl Anderson, 607 Seitz Ave., Mayville, Wis. m7tfn

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FOR SALE: Equipment of retiring physician, including National cautery; two Hamilton steeltone examination room suites—one buff, one white; Birtcher crystal bandmaster diathermy, with surgical attachments; accessories; various small instruments and treatment room supplies. Contact Mr. Harvey Schellpfeffer, 44 N. Main St., Mayville, Wis. m7tfn

INDEX TO ADVERTISERS

Ames Company ---------- 47

Barr X-ray Co. ---------- 42
Benson Optical Company ---------- 11
Borden's ---------- 40
Burroughs Wellcome & Co., Inc. ----------15, 32

Chatham Pharmaceuticals, Inc. ---------- 29

Davies, Rose & Company, Ltd. ---------- 29

Endo Laboratories ---------- 41

Glenbrook Laboratories ----------6, 13

Haug Drug Company ---------- 26
Hotel Schroeder ---------- 34
House of Bidwell, Inc. ---------- 42
Hurley X-ray Company ---------- 40

Keeley Institute ---------- 34

Lederle Laboratories ----------16, 17, 36
Lilly and Company, Eli ----------Front cover, 20

Medical Protective Company ---------- 31
Milwaukee Sanitarium Foundation ---------- 40

Parke, Davis & Company ----------2, 3
Physicians Exchange ----------43, 44, 45
Poythress & Co., Inc., Wm. P. ---------- 38

Rennebohm's ---------- 40
Robins Co., Inc., A. H. ---------- 12
Roche Laboratories ----------Back cover
Rogers Memorial Hospital ---------- 31

Sacred Heart Sanitarium ---------- 46
Saint Mary's Hill Hospital ---------- 28
St. Croixdale Sanitarium ---------- 4
Schering Corporation ---------- 19
Searle & Co., G. D. ---------- 21
Shorewood Sanitarium ---------- 42
Smith Kline & French Laboratories ---------- 18
Squibb & Sons, E. R. ---------- 24

Time Insurance Co. ---------- 42
Tutag & Co., S. J. ---------- 4

Wallace Laboratories ---8, 9, 22, 23, 30, 34, 37, 39
Winthrop Laboratories ----------10, 14, 25
Wisconsin Physicians Service ---------- 33

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An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Fully accredited. Literature and rates sent on request.

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the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

CONTENTS

Vol. 62, No. 8 AUGUST 1963

SCIENTIFIC ARTICLES

Gastric Surgery, by W. B. Gallagher, M.D., F.A.C.S., La Crosse ---------- 334

Secondary Abdominal Pregnancy, by Milton F. Gutglass, M.D. and Yasar Atamdede, M.D., Milwaukee ---------- 337

Primary Fibroleiomyosarcoma of Spermatic Cord; case report, by Marvin Wagner, M.D. and Joseph L. Teresi, M.D., Milwaukee --- 342

Anaphylactic Reaction to Trypsin; case report, by R. R. Liebenow, M.D., Lake Mills ----- 347

Clinicopathologic Conference, by R. D. Bartholomew, M.D., Wausau ---------- 349

SPECIAL ARTICLES

Rabies in Wisconsin, by Alfred S. Evans, M.D., M.P.H., Madison ---------- 329

Death Following Carotid Sinus Pressure (abstract) ---------- 333

Schedule—Orthopedic Field Clinics -------- 349

Abuse of One Pint Transfusions (abstract) --- 352

Comments on Treatment: Pharmacology of Methyldopa; an Antihypertensive Drug, by Bert K. B. Lum, Ph.D., M.D., Milwaukee --- 353

Plasma Proteins and the Gastrointestinal Tract (abstract) ---------- 355

Are Verbal Rxs to a Patient—Advisable? --- 360

Minutes of Council Meeting, Milwaukee, May 5, 1963 ---------- 361

Fetal Hearts from Mount Sinai Transmitted to Paris Via Relay Satellite ---------- 39

Medical School Graduates Trained in Far Off Madagascar and South Vietnam ------- 40

EDITORIALS

President's Page: The Trio Became a Quartet, by W. J. Egan, M.D., Milwaukee ------- 356

The National Anguish ---------- 358

Guest Editorial: Calling All Counties ------ 359

Earl R. Thayer: Friend of Medicine ------- 360

REGULAR FEATURES

Facts about Wisconsin Physicians Service --- 12

County Society Proceedings ---------- 23

Specialty Society Proceedings ---------- 27

News of Wisconsin Physicians ---------- 31

Obituaries ---------- 41

Society Records ---------- 45

Medical Meetings ---------- 53

Physicians' Exchange ---------- 61

Index to Advertisers ---------- 64

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Journal
Established 1903
Annual Subscription-------$6.00
Single Copy---------- 1.00
Previous Years'---------- 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 303 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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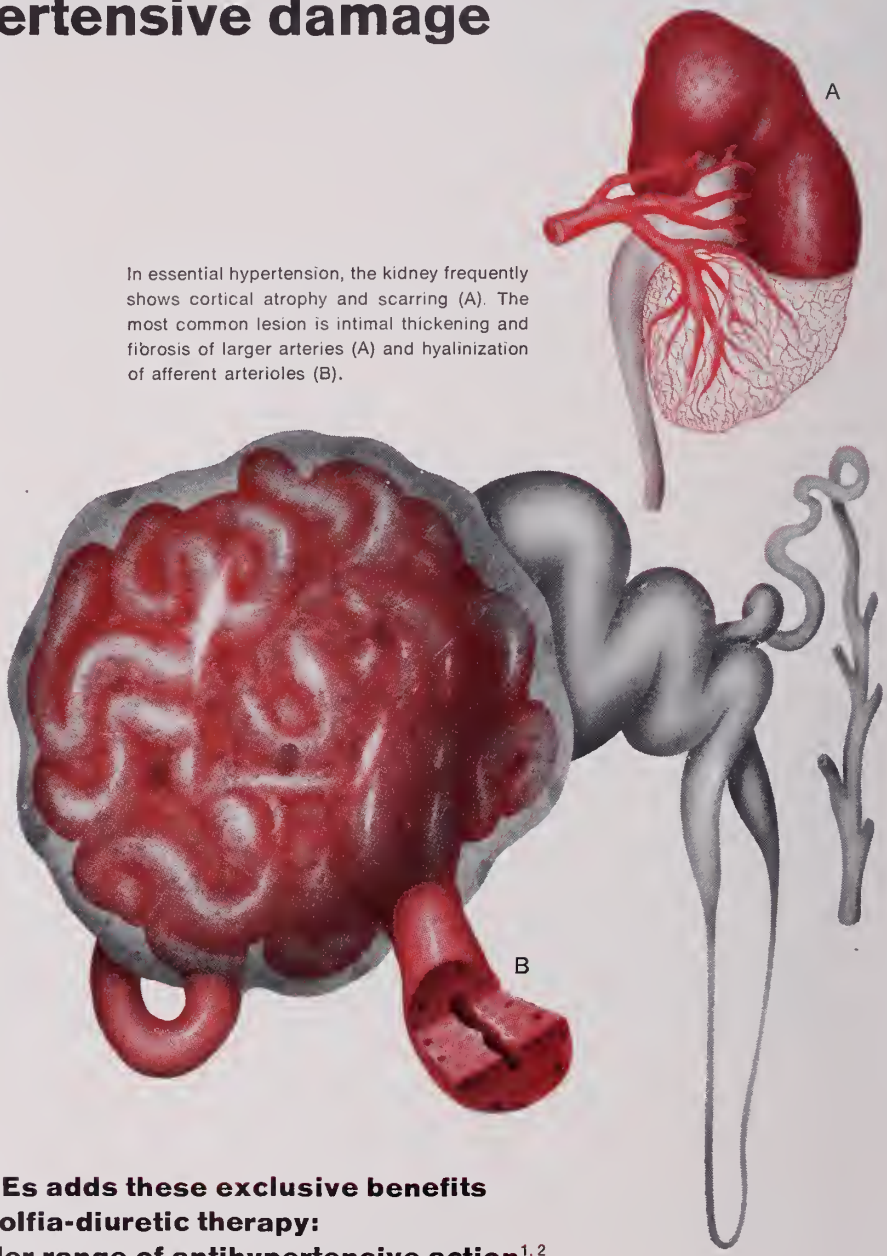

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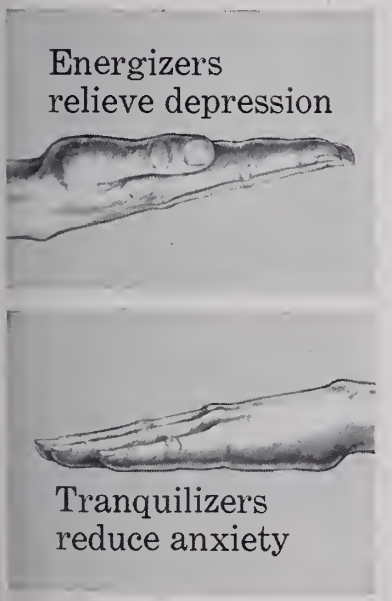

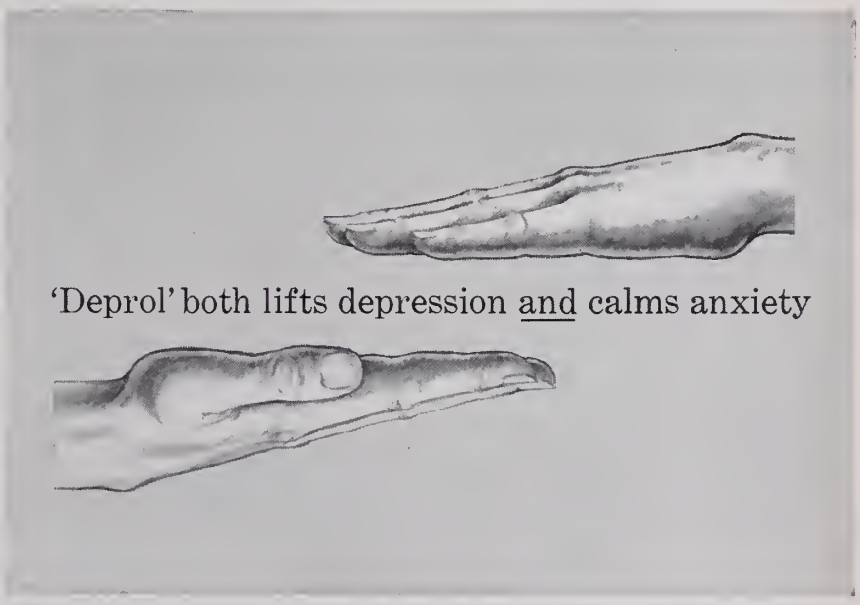

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COUNTY SOCIETY PROCEEDINGS

BROWN

Dr. Douglas A. Gutheil, DePere, addressed the Brown County Medical Society at a meeting held May 16 in the Northland Hotel, Green Bay. His subject was "Tuberculosis Eradication," which was heard by 31 physicians.

Mr. Mark Wood, of Carmel, Ind., spoke to the group on services in communications which he had rendered to three local hospitals. He recommended a pamphlet which he had specially prepared for the medical profession, entitled "Hospital Bound Prescription for P.L.C. (Professional Loving Care)."

In response to the Final Report of the Citizens Study Committee published by the United Community Council of Brown County, the Society's Advisory Committee recommended, and it was approved, that the Brown County Welfare Council be the coordinating body and that the Council be represented on the coordinating body by a single physician who would receive his instructions from a special Brown County Medical Society Advisory Committee which has as its sole function the instruction of this physician representative on the Brown County Welfare Council.

Drs. J. L. Ford, Green Bay, and *B. P. Waldkirch*, DePere, delegates, reported on the House of Delegates actions at the annual meeting of the State Medical Society May 6–9 in Milwaukee. *Dr. Lyle H. Edelblute*, Green Bay, reported on the Booz, Allen & Hamilton management survey report which was submitted to the House of Delegates at the annual meeting.

DANE

A full report of the management survey of the State Medical Society, conducted by the management survey firm of Booz, Allen & Hamilton, was presented to the general membership of the Dane County Medical Society at an executive session June 11 at SMS headquarters in Madison.

LA CROSSE

The May 20 meeting of the La Crosse County Medical Society heard *Dr. M. C. F. Lindert*, Milwaukee, La Crosse with 61 members attending. Major topic was reports by the delegates to the State Medical Society.

MARATHON

Thirty-one members of the Marathon County Medical Society heard *Dr. M. C. F. Lindert*, Milwaukee, discuss "Diagnostic Problems of the Jaundiced Patient" at the June 24 meeting held at The Wausau Club in Wausau. The next meeting will be a business session involving revision of the Constitution. It is tentatively scheduled for September 23.

Physicians whose names appear in italic are members of the State Medical Society.

PIERCE–ST. CROIX

Dr. Jerome Hilger, St. Paul doctor and author of medical texts, was the speaker at the May 21 meeting of the Pierce–St. Croix County Medical Society held at the Captain's Table in Prescott. Doctor Hilger spoke on micro-surgery of the ear and current research techniques. *Dr. Howard Laney* of Prescott was host of the meeting and a dinner.

The June 18 meeting was held at Lu-Gen's in Knapp. On July 16 the Society met at the River's Edge in Somerset at which time members saw a movie, "Good Ship Hope," narrated by F. W. Quattlebaum.

PRICE–TAYLOR

On May 25 members of the Price-Taylor County Medical Society met at the Skyline Club in Phillips for a scientific and business session. On the scientific program were *Drs. Thomas G. Olsen* and *John W. Rupel* of the Marshfield Clinic. Doctor Olsen discussed "Hidden Fractures" while Doctor Rupel discussed "Fibrinogen Deficiency in Pregnancy."

Glenn C. Waldschmidt, regional representative of the State Medical Society, showed a movie and gave some explanatory remarks on "Operation Hometown."

The following officers were elected during the business session: president, *Dr. J. D. Leahy*, Park Falls; vice-president, *Dr. W. E. Niebauer*, Phillips; and secretary, *Dr. J. L. Murphy*, Park Falls.

RACINE

A panel of attorneys, composed of Alfred LaFrance, Harley Brown, and Bob Weber, discussed "Legal Medical Problems" at the May 16 meeting of the Racine County Medical Society held at the Meadowbrook Country Club.

On June 20 the Society met at the Racine Country Club for a business meeting and discussion of "Proposed Revised Constitution and Bylaws."

RICHLAND

The Richland County Medical Society met May 2 at the Richland Hospital library in Richland Center. *Dr. P. T. Bland* of Westby showed a colored film of the 1963 Westby Ski Meet.

SAUK

On May 14 *Dr. B. H. Roisum*, a psychiatrist of Madison, was guest speaker at the Society meeting

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TREMPEALEAU–JACKSON–BUFFALO

The Tri-County Medical Society met June 25 at The Club Kahlua in Fountain City. Dr. Charles Rogers, Winona, Minn., pediatrician, was guest speaker.

SWIMMERS' ITCH

Many resorts and cottage owners in Wisconsin have recently corresponded with the Wisconsin State Board of Health regarding the incidence of "chigger-like" bites affecting swimmers on natural lake beaches. In some lakes the condition is so severe that nearly all swimmers are affected during most of the summer months. The cause of swimmers' itch is a schistosome cercariae, and the condition is generally distinguishable from the tormbiculid (chigger-mite) condition by the distribution pattern of penetration spots on the skin. Chiggers most commonly attack the legs and restricted areas around the groin, waistline, and under the arms, whereas swimmers' itch lesions are more commonly distributed in a random pattern over the entire body except for the neck and head. Swimmers' itch lesions do not develop water blisters characteristic of poison ivy, nor does the infection spread from the point of penetration of the cercariae. Because of the nature of the affliction, it is not contagious like many bacterial infections.

In swimmers' itch, the cercariae may penetrate into the epithelial layer of the skin of bathers. These cercariae die within a short time after penetration, but several hours later a red spot may be noticed and severe itching is characteristic. Severity of individual cases varies greatly. Some persons are immune to attack; others are only mildly affected and some are affected to such an extent that they may require extensive medical treatment. Oddly, repeated exposure has a tendency to sensitize the skin to the cercariae and repeated exposures tend to become much more severe than first exposures.

The most usual approach to the control of swimmers' itch on natural beaches has been through the application of chemicals toxic to the snail population. In general the swimming areas are treated with copper sulphate and copper carbonate at a rate of approximately two pounds copper sulphate and one pound copper carbonate per thousand square feet of bottom. Snails, the host of the cercariae, are killed as a result of the toxicity of the chemical used. In general fish are not adversely affected since the chemical is irritating and fish will normally leave the treated area. The State Board of Health would normally suggest approximately 200 to 500 feet of shoreline to be treated where the swimmers' itch condition occurs.

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SPECIALTY SOCIETY PROCEEDINGS

Wisconsin Surgical Society

Dr. C. Morrison Schroeder, Milwaukee, was elected president of the Wisconsin Surgical Society at its annual meeting held May 9 at the Milwaukee Auditorium. Other officers are: *Dr. Norman O. Becker*, Fond du Lac, president-elect; *Dr. John T. Mendenhall*, Madison, secretary-treasurer; and *Dr. Sigurd B. Gundersen, Jr.*, La Crosse, recorder.

Councilors to serve for three-year terms are *Drs. Henry F. Twelmeyer*, Wauwatosa, and *Russell P. Sinaiko*, Madison.

The Section on Surgery of the State Medical Society also elected the following officers at the same time: *Dr. C. Morrison Schroeder*, Milwaukee, chairman; *Dr. John T. Mendenhall*, Madison, secretary; *Dr. Jack A. Killins*, Green Bay, delegate; and *Dr. Albert G. Martin*, Milwaukee, alternate delegate.

Wisconsin–Upper Michigan Society of O–O

Theda Clark Memorial Hospital in Neenah was host for a scientific meeting of the Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology held June 8 and 9. The program included the following: "Mid-facial Injuries" by Dr. Jerome Hilger, University of Minnesota, St. Paul; "Practical Management of the Glaucomatous Individual" by Dr. Joseph Haas, University of Illinois, Chicago; "Vertigo" by Doctor Hilger; and "Surgery in the Open Angle Case" by Doctor Haas.

Physicians and their wives were entertained at a tea and humorous program at the residence of *Dr.* and Mrs. *John Conway*, Menasha. A social hour and dinner was held at the Butte-des-Morts Country Club. Following dinner a local artist, Mr. Henry Young, presented a program on "Art Subjects and Pictures." Doctor Conway is president of the society.

VA–Marquette Clinical Day

The sixteenth annual clinical day of the Veterans Administration Hospital, Wood, and Marquette University School of Medicine's Dean's Committee was held June 15 at the hospital. Scientific papers were presented by Drs. Gerald T. Roling (hematology), James R. Felker (internal medicine), Ruedi Gingrass (surgery), George Johansen (otolaryngology), Joseph Hanrahan (urology), *Dean D. Miller* (internal medicine), Charlotte Hill (ophthalmology), *Thomas O'Connor* (thoracic surgery), Albert L. Nichols (internal medicine), Ernest L. Burnell (internal medicine), and Lewis R. Knox, D.D.S. (periodontics).

Moderators for the program were *Drs. Derward Lepley* and *Joseph Rastetter*. Scientific papers were evaluated by *Drs. Edwin H. Ellison, James J. Smith*, and *M. C. F. Lindert*.

The Staff Award for the best scientific paper was presented to Dr. Ruedi P. Gingrass, resident in surgery, by Dr. Stephen A. Close who also presented certificates to the others.

Physicians whose names appear in italic are members of the State Medical Society.

Milwaukee Gynecological Society

Dr. Robert E. McDonald, Milwaukee, was elected president of the Milwaukee Gynecological Society at its annual meeting held May 13 at the University Club of Milwaukee. *Dr. Saul F. Schwartz*, Milwaukee, was elected vice-president. *Dr. Jack A. Klieger*, Milwaukee, will continue for another year as secretary-treasurer to complete his two-year term.

AAPS Essay Winner from Wisconsin

Susan Morphew, Whitewater high school junior, received a $75 award for placing 12th in the Association of American Physicians and Surgeons 1963 national essay contest on the subjects, "The Advantages of Private Medical Care" and "The Advantages of the American Free Enterprise System." Prior to entry in the national contest, Susan won the Walworth county contest and then the state contest to qualify her for the national event. *Dr. James F. Baumgartner*, West Bend, was chairman of the Wisconsin essay contest. First prize in the national contest was $1,000.

State Medical Assistants Society

At the annual meeting of the Wisconsin State Medical Assistants Society, held June 7–9 in Sheboygan, the following officers were elected: Miss Edith C. Murphy, Milwaukee, president; Mrs. Aleen Piepenburg, Waukesha, president-elect; Miss Esther Hartwig, Milwaukee, recording secretary; and Mrs. Gwendolyn Selchert, Janesville, treasurer.

Edith C. Murphy

Miss Murphy is a secretary and supervisor in the offices of *Drs. E. R. Daniels, W. L. Deardorff, C. L. Junkerman, J. K. Olinger*, and *J. S. Ziolkowski*, Milwaukee. She is a charter member of the WSMAS and the American Association of Medical Assistants. She has served as president of the Milwaukee County Medical Assistants Society and has been a member of the state executive board for a number of years. As an elected delegate, she represented the Wisconsin medical assistants at an-

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nual meetings of the AAMA in Reno, Chicago, and San Francisco. In addition to her presidential duties in the state, Miss Murphy is currently chairman of the AAMA membership committee.

Wisconsin Public Health Association

Over 250 people were in attendance at the opening session of the Wisconsin Public Health Association's annual meeting, held June 18 and 19 at the Wisconsin Center in Madison.

S. Stephen Kegeles, Ph.D., assistant director of the Public Health Practice Research Program at Michigan State University opened the session with a look at the "Image of Public Health."

Doctor Kegeles pointed out that the public health image can be divided roughly into three parts: the image as it looks to public officials; as it looks to professional workers; and as it looks to the general public. On the higher levels of government the image is apparently quite good as adequate funds have generally been provided to enable public health technology to make rapid strides. With professional people in health, the image apparently declines, Doctor Kegeles said. The difficulty in attracting professional workers to the field is one indicator. Another is medical students' low rating of public health careers on their scale of work preferences. With the general public, the image again leaves something to be desired, he said. Public apathy toward many public health programs is apparent. As an example, he cited the failure of most of our population to protect themselves against polio by immunization as urged in all public health programs.

The June 19 session was highlighted by an address by Dr. Thomas Hood, vice-president of the American Public Health Association. Doctor Hood's talk was open to the general public.

Dr. LeRoy Burney, former surgeon general of the United States, who had been scheduled to speak on Wednesday was called to Washington D.C. to testify before a legislative committee.

The meeting also included several special interest sessions: "Chemicals in our Lives;" "Home Nursing Care;" "The Problems of an Expanding Population;" "Community Organization;" "Wholesome Food;" and previews of recent health films.

Those attending the two-day session included workers in public health from throughout the State.

Betty Krippene, Oshkosh, was elected for a second term as president of the association at the conclusion of the meeting. Miss Krippene is a State Board of Health dental hygienist.

Other officers and directors elected are: Ione Rowley, president-elect, Madison; Vivian Holland, vice-president, Madison; Paul Schuster, secretary-treasurer, La Crosse; Edward Friday, director, Madison; and Dr. Michael Arra, Director, Madison.

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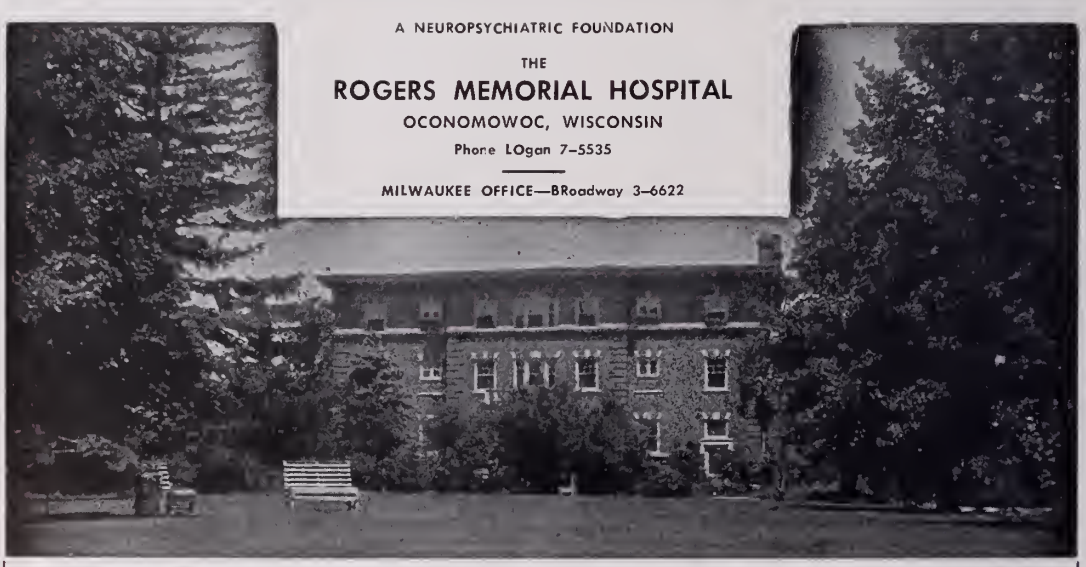

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NEWS OF WISCONSIN PHYSICIANS

Board Certification Announced

Dr. J. W. Rupel, Marshfield Clinic specialist in obstetrics and gynecology, recently has been certified by the American Board of Obstetrics and Gynecology.

Dr. Reichle to Practice in Clintonville

Dr. Robert Reichle, a graduate of Ohio State University of Medicine, who interned at Duluth, Minn., plans to locate in Clintonville in the private practice of medicine about October 1, 1963.

Dr. Royce Moves to Hawaii

Dr. Marvin E. Royce recently announced that his medical practice in Mayville was being discontinued. He had practiced medicine in Mayville for 13 years, prior to his leaving June 1, 1963, to establish residence in Hawaii.

Dr. Fuller Joins Monroe Clinic

Dr. John R. Fuller, specialist in otolaryngology, recently joined the staff at The Monroe Clinic. Formerly an instructor at the University of Minnesota, Doctor Fuller received his M. D. degree from the University of Vermont, and completed his internship at the Mary Fletcher Hospital, Burlington, Vt. He served a military residency at Walter Reed General Hospital, Washington, D. C. from 1954–1955.

Doctor Fuller has been awarded a grant to do research on the ear by the National Institutes of Health.

Dr. Stoll Receives Board Certification

Dr. William M. Stoll, Green Bay surgeon, has been certified a diplomate of the American Board of Thoracic Surgery.

Doctor Stoll received his medical degree in 1952 from Marquette University School of Medicine. He served a four-year residency in general surgery at the Methodist and Raymond Blank Children's Hospitals in Des Moines, Ia.; and a one-year residency in thoracic and cardiovascular surgery at Ford Hospital in Detroit. He was a fellow in cardiovascular surgery at the University of Minnesota Hospital for 15 months, and chief resident in lung surgery at Glen Lake Sanatorium in Minneapolis. He was certified by the American Board of General Surgery in 1959.

Physicians whose names appear in italic are members of the State Medical Society.

Dr. Jackson Retires as Clinic Manager

Dr. Arnold S. Jackson, Madison, president and director of the Jackson Clinic for the past 25 years, has retired from management of the clinic. He will continue to practice medicine at the clinic; however, his managerial duties will be assumed by *Dr. Luther Holmgren.*

Doctor Jackson received his M. D. degree from Columbia University, and served a four-year surgical residency at Mayo Clinic, prior to joining the Jackson Clinic in 1922.

Doctor Holmgren will be succeeded as clinic vice-president by *Dr. H. C. Ashman*; *Dr. H. W. Mahaffey* succeeds Doctor Ashman as treasurer, and *Dr. J. J. Mueller* will continue as secretary.

Dr. Rosenbaum Speaks at AMA Meeting

For the second consecutive year, the American Heart Association and the American Medical Association cosponsored a symposium at the AMA's Annual Meeting this June at Atlantic City, N. J. The session was on the subject, "Modern Concepts of Myocardial Infarction." Jointly sponsored by the AMA's Council on Clinical Cardiology and the AMA's Section on Internal Medicine, the program was introduced and moderated by *Dr. Francis F. Rosenbaum*, Milwaukee, Associate Clinical Professor of Medicine, Marquette University School of Medicine. Doctor Rosenbaum is on the Board of the Wisconsin Heart Association.

Dr. Pyka Wins Scholarship

Dr. Rudolf A. Pyka, orthopedic surgeon at the Marshfield Clinic, was recently awarded a scholarship by the National Society for Crippled Children and Adults. Scholarships were awarded to physicians, therapists, educators, and other specialists who will take training throughout the country in programs which have the guidance or participation of a member of the

American Academy for Cerebral Palsy. The awards are designed to provide additional specialized training in learning new techniques and methods in the rehabilitation and employment of the crippled.

Discuss Chest Physicians Program

Dr. Andrew L. Banyai, clinical professor of medicine, emeritus, Marquette University, Milwaukee, is shown with Dr. Li Shu-Fan, founder of the Li Shu-Fan Medical Foundation in Hong Kong, looking over the scientific program for the American College of Chest Physicians twenty-ninth annual meeting held in Atlantic City, N. J., June 13–17. Doctor Banyai serves as director of international affairs of the College and Doctor Li is regent for the College in free China.

Six Wisconsin Physicians Named Diplomates

It was recently announced by the American Board of Pathology that six Wisconsin physicians have passed the semi-annual examination held this spring for certification as diplomates in pathology. Physicians named are:

B. J. Bauman, M. D.—Madison
S. L. Inhorn, M. D.—Madison
G. W. Holmes, M. D.—Marinette
B. A. Myhre, M. D.—Milwaukee
Reza Soltani, M. D.—Milwaukee
M. A. Litton, M. D.—Rhinelander

Dr. Zach Speaks in Madison

Dr. Robert G. Zach, Monroe, recently addressed a meeting of the Southwestern Wisconsin Claims Association in Madison. His subject was, "Health Fads, Frauds and Fallacies."

National Institute Awards Grants

It was announced recently that four grants would be awarded the University of Wisconsin by the National Institutes of Health.

Dr. J. M. B. Bloodworth, Jr., was awarded a one-year $30,532.00 Arthritis grant.

Dr. C. W. Crumpton was awarded a one-year $66,200.00 Heart Training grant.

Dr. Q. R. Murphy was awarded a one-year $40,000.00 Heart Training grant.

Dr. W. B. Youmans was awarded a one-year $29,268 Heart Training grant.

Doctor Schammel Heads United Givers

Dr. F. M. Schammel was recently named chairman of the 1963 United Givers Campaign in the Stoughton area. The campaign will begin in October of this year.

Arthritis Forum Held

"The Positive Side of Arthritis Treatment," was discussed by *Drs. Albert Cohen* and *Aaron Sweed*, specialists in physical and internal medicine, respectively, at a free public forum on arthritis held in Waukesha during the month of June. The forum was open to the public, and was free, being sponsored by the Greater Waukesha United Fund.

Dr. John K. Curtis Cited

Dr. John K. Curtis, chief of medical service at the Madison Veterans Administration Hospital, recently received the chief medical director's commendation from the VA area medical director, Dr. Edward Mandell. The citation is made annually to one of the outstanding chiefs of service. Doctor Curtis practiced in Madison before joining the VA staff in 1951 and is now a professor of medicine at the University of Wisconsin.

Dr. Ben M. Peckham Receives Award

The first annual Medical Alumni Award for Distinguished Teaching at the University of Wisconsin Medical School was given to *Dr. Ben M. Peckham*, Professor and Chairman of the Department of Gynecology and Obstetrics. Doctor Peckham was selected by the Senior Class to receive the initial award.

Wisconsin Cheese Big Hit at AMA Meeting in Atlantic City

A 186-pound wheel of Swiss cheese proved the hit of the "Wisconsin Room" at the convention of the American Medical Association June 16–20 in Atlantic City, N. J. Shown here ore from the left: *Dr. John M. Bell*, Morinette, ond *Dr. W. B. Hildebrand*, Menasho, olternote delegotes to the AMA from Wisconsin; *Dr. W. D. Stovoll*, Madison, member of the AMA Council on Constitution ond Bylows; ond *Dr. James C. Fox*, Lo Crosse, choirmon of the SMS Council. The cheese wos provided by the Green County Medicol Society ond the mop of Wisconsin in the background, composed of o voriety of pills, wos made by *Dr. Robert G. Zoch*, Monroe.

U of Wisconsin MD's Give Lectures

Dr. Francis M. Forster, Department of Neurology at the University of Wisconsin, participated in the French and Swiss Neurological Meetings from May 14–21. Doctor Forster also visited the Brain Research Institute in Zurich, Switzerland.

Dr. John Anderson, Department of Anatomy at the University of Wisconsin recently visited the Medical Center in Memphis, Tenn. He delivered a lecture on May 14 on "The Transfer of Immunity from Mother to Young," and on the 15th he spoke on the "Histochemistry of Parakeratosis in Pigs with Comparisons with Human Psoriasis."

Dr. Melvin Kaufman, Department of Child Psychiatry at the University of Wisconsin, recently presented a paper at the meeting of the American Association on Mental Deficiency in Portland, Ore. The paper was entitled, "Stereotyped Self-Oriented Behaviors in Mental Defectives."

Dr. Frances Graham, Department of Pediatrics, presented an invited address in May at the 50th Anniversary Celebration of the Louisville Child Guidance Clinic. Doctor Graham's subject was, "Brain Injury in the Young Child."

Dr. Seymour Halleck, Department of Psychiatry, recently spent two days at the Illinois Juvenile Court Work Conference in Chicago. As part of the program, street gangs were brought in to be questioned by the judges.

Drs. Peter Duehr, Frederick J. Davis, and *Matthew D. Davis*, Department of Surgery (ophthalmology) at the University attended the meeting of the Chicago Ophthalmological Society in Chicago on May 24–25.

Dr. Gordon Davenport, Department of Plastic Surgery, attended an Interstate Plastic Surgery Society meeting in Cleveland from May 30 to June 2.

Dr. Gabriele ZuRhein recently visited neuropathology laboratories in New York. He also attended the meeting of the American Association of Neuropathologists and meeting of the American Neurological Association in Atlantic City.

Doctor Webster Talks to Dentists

Dr. John G. Webster, of the Manitowoc Clinic, spoke early in June at a joint meeting of the Manitowoc County Dental Society and Dental Surgical Staff of Memorial Hospital, Manitowoc, on oral cancer. Doctor Webster told the group that five per cent of all cancer is found in the mouth and early detection doubles the cure rate of the disease. The dentists were urged to make use of this test and others so that cancer can be found and treatment can be started early. From left are Dr. Stephen Mann, president-elect of Manitowoc County Dental Society; Dr. Richard Sell, president; Dr. Ralph Petersen, public education chairman; and Doctor Webster who is demonstrating a painless smear technique by which certain suspicious oral lesions can be screened to determine if they are cancerous.

Clinical Conference Held at Monroe

Thursday, May 23, 1963, was chosen as clinical conference day at The Monroe Clinic. Exhibits were held in the Departments of Surgery, X-Ray, Neurosurgery, Urology, Eye, Laboratory, and General. The conference included lectures by staff members including:

Dr. L. F. Scribner, Jr. Department of Allergy, "Recognizing and Treating Common Lung Diseases."

Dr. R. R. Baumann, Department of Dermatology, "Will the Real Ringworm Please Stand Up."

Dr. J. R. Fuller, Department of Ear, Nose and Throat, "Current Treatment of Hearing Loss."

Guest speaker, *Dr. William S. Middleton*, former Dean of the University of Wisconsin Medical School, and former Chief Medical Director of the VA, lectured on "Connective Tissue Diseases in General Practice."

State OB Physicians Attend Annual Meeting

The eleventh annual clinical meeting of the American College of Obstetricians and Gynecologists was held April 21–24 at the Statler Hilton Hotel in New York.

Wisconsin physicians lecturing were:

Dr. R. D. Neubecker, Marshfield, "Teratocarcinoma of the Ovary."

Drs. F. J. Hofmeister and *Dorothy M. Barbo*, Milwaukee, "Cancer Detection in the Private Practice of Gynecology: A Concluding Study."

Drs. R. A. Pattillo, *D. V. Foley* and *R. F. Mattingly*, Milwaukee, "Lymphography in Carcinoma of the Cervix."

Dr. B. M. Peckham, Madison, "Benign Ovarian Tumors."

Dr. R. F. Mattingly, Milwaukee, "Surgical Injury to Bladder and Ureter."

Dr. F. J. Hofmeister, Milwaukee, was invited to participate in a panel discussion entitled, "Geriatric Gynecology," and also gave an address on "Endometriosis."

Chest Physicians Meet

The 29th Annual Meeting of the American College of Chest Physicians was held June 13–17 at the Ambassador Hotel in Atlantic City, New Jersey. *Dr. John Rankin*, Madison, was invited to participate in a roundtable discussion covering recent advances in the diagnosis and treatment of cardiopulmonary disease; his particular topic being, "Respiratory Acidosis."

S.A.M.A. Foundation Preceptorship Program

Names of the ten medical students to receive Sears-Roebuck Foundation Preceptorship Scholarships for 1963 included one from Wisconsin. Under the S.A.M.A. Foundation preceptorship program selected junior and senior medical students will practice two months in communities having participated in The Sears-Roebuck Foundations Community Medical Assistance Plan. These communities have all obtained doctors and have constructed the uniquely designed medical center of the Foundation. Each recipient receives $500 from the Foundation plus room and board provided by the physician or the community. This is the second year of the Preceptorship Program.

Charles Strub, student of the University of Wisconsin Medical School, will work with Dr. Robert Koop of Darrington, Wash., from June 10 to August 10.

Craig Ray, Jr., student of Emory University, will work with *Dr. Robert Adams* and *Joseph Powell* in Chetek, Wis., from June 10 to August 10.

The ten students chosen were reviewed and approved by the Medical Advisory Board of the Foundation.

Dr. Kilkenny Named Chief of Staff

The appointment of *Dr. George S. Kilkenny* as Chief of Staff of St. Joseph's Hospital, Milwaukee, has been announced by Sister M. Madeleine, O.S.F., Administrator. Doctor Kilkenny succeeds *Dr. Samuel A. Rosenthal,* who served nine years in the position. Also announced was the appointment of *Dr. Wilson W. Weisel* as Chief of Surgery, succeeding *Dr. Joseph J. Gramling, Jr.*

Doctor Kilkenny, a 1931 graduate of the Marquette Medical School, has served on the staff of St. Joseph's since 1936. He was Chief of Obstetrics-Gynecology from 1952 to 1958. He is a past president of the Wisconsin Society of Obstetrics-Gynecology, and president of the Milwaukee Gynecological Society. He is an Associate Clinical Professor of Obstetrics-Gynecology at Marquette medical school.

Doctor Weisel, a 1938 graduate of the Harvard Medical School, has been head of the section of thoracic surgery at St. Joseph's since 1961, and a member of the staff since 1945. He is an Associate Professor of Surgery and head of the Thoracic-Vascular Section at Marquette medical school.

New Clinical Pathological Laboratory

A new clinical pathology laboratory, part of four proposed medical clinics in Beaver Dam, has been completed. Dr. William G. Richards and Dr. Theodore Rowan, pathologists, are presently operating the laboratory. Covering all of Dodge County, they make daily visits to St. Mary's Hospital, Watertown; St. Mary's Hospital, Columbus; Waupun Memorial Hospital, Waupun; and the two Beaver Dam hospitals.

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Two Physicians Join Riverside Clinic

The Riverside Clinic, Menasha, announced recently the addition of two physicians to its medical staff. Dr. W. David Gemmill, a pediatrician, joined the clinic on August 12. He was born in Shaker Heights, O., and graduated from Williams College, Williamstown, Mass., in 1955. His medical education was received at Ohio State University School of Medicine, Columbus, where he graduated in 1959.

Doctor Gemmill interned at St. Luke's Hospital, Columbus, O., in 1960. He served his residency in pediatrics at Children's Hospital, Columbus, from 1960 through 1963 being chief resident in 1962 and 1963. Doctor Gemmill received the degree of Master of Medical Science in 1963. Doctor Gemmill and his family live in Neenah.

Dr. F. L. Schaefer joined the staff of the Riverside Clinic as an obstetrician and gynecologist on July 15. Doctor Schaefer was born in Wilmington, Del., and received his Bachelor of Arts degree from Miami University in Oxford, O., graduating in 1952. He received his medical degree from the University of Cincinnati College of Medicine in 1956, interning in Cincinnati General Hospital in 1957.

Doctor Schaefer served a four year residency in the Department of Obstetrics and Gynecology at Ohio State University Hospital, Columbus, from 1959 through 1963. During his last year he was chief resident. He received the degree of Master of Medical Science in June, 1963, from Ohio State University. From 1957 through 1959 Doctor Schaefer served in the United States Marine Corps. Doctor Schaefer and his family are also living in Neenah.

Hippocrates Type Tree Planted at UW

Representatives of the University of Wisconsin Medical Center in June planted a Greek plane tree, of the type Hippocrates taught under, in front of the University Hospitals. The tree is one of three "Mediterranean Sycamores" brought by the Greek ambassador to the United States for a ceremonious planting at the National Library of Medicine in Bethesda, Md. The tree was obtained by *Dr. William S. Middleton*, emeritus dean of the UW medical school and former chief medical director of Veterans Administration.

Present for the planting were Doctor Middleton, Prof. Helen Crawford, school librarian; Dr. James Crow, acting dean of the school, professor of medical microbiology; *Dr. W. D. Stovall*, emeritus professor of medicine and special assistant to the dean; and *Dr. Otto Mortensen*, assistant dean and professor of anatomy; and *Dr. Hans Reese*, emeritus professor of neurology.

Abolish Psychiatrist Post

The position of full-time psychiatrist at the Winnebago County Guidance Center was abolished by the county board at a meeting held in June in Oshkosh. At the same time, the board authorized the guidance center board of directors to hire a full-time psychiatric social worker and retain a psychiatrist on a part-time fee basis. *Dr. George Arndt*, medical director and full-time psychiatrist at the guidance center, resigned a week before the meeting. The abolishment of the full-time psychiatric post appeared to be a compromise to obtain approval of the social worker which guidance center directors said was needed to help reduce the backlog of cases.

Doctor Burris Honored by Election

Dr. B. Cullen Burris, Milwaukee, has recently been elected president-elect of the Central Neuro-Psychiatric Hospital Association. He also has been named a member of the membership committee of the National Association of Private Psychiatric Hospitals. Doctor Burris is president of the Milwaukee Chapter of the Wisconsin Psychiatric Association and for some time has been on the Council of the WPA.

Heart Clinic at Superior

A rheumatic fever and congenital heart disease clinic was held in June at St. Mary's Hospital in Superior. The Wisconsin Heart Association and the Douglas County Medical Society sponsored the clinic. *Drs. Mortimer Bortin* and *William J. Smiles* examined about 25 patients who were referred to the clinic by their physicians. Doctor Bortin is assistant clinical professor of medicine at Marquette University and Doctor Smiles is an internist in Ashland.

Breaks Ground for Hospital Project

Dr. Spencer D. Beebe, dean of west Wisconsin physicians, turned the first spadeful of dirt marking the start of construction of a new $1.5 million improvement project for St. Mary's Hospital, Sparta. After surveying the crowd in attendance for the ground breaking, Doctor Beebe's remark was, "Surely, this is a foretaste of heaven."

Named Director of Tomah VA Hospital

Dr. Herman E. Wilkinson, chief of staff at the Brecksville, O., Veterans Administration hospital has been named director of the VA hospital at Tomah, replacing Dr. Aaron S. Mason, who was transferred to the Lexington, Ky., Veterans Administration hospital on June 23.

Doctor Wilkinson received his medical degree at Ohio State University. He served in the U. S. Army Medical Corps from April, 1941, to January, 1946, and from April, 1949, to June, 1952, attaining the rank of lieutenant colonel. He was in private practice in Ohio.

He joined the VA's hospital system in 1947 at the hospital at Lexington, Ky., and served in VA hospitals at Erie, Pa., and Chillicothe, O., as chief of staff. He also served at Bay Pines, Fla., before becoming chief of staff at Brecksville.

Doctor Gedge to Mayo Clinic

Dr. Stafford W. Gedge has been appointed to the staff of the Mayo Clinic, Rochester, Minn., as a consultant in medicine. Doctor Gedge completed a residency in medicine at the Mayo Foundation, Rochester, Minn., a part of the Graduate School of the University of Minnesota, in July 1961, and since that time he has been in practice at the Marshfield Clinic, Marshfield. Doctor Gedge received the degree of master of science in medicine from the University of Minnesota in July 1961.

ACCP Fellowships to Two Physicians

Certificates of Fellowship in the American College of Chest Physicians were conferred upon two Wisconsin physicians, along with 273 others, during convocation ceremonies at the twenty-ninth annual meeting of the College in Atlantic City, N. J., June 16. They are *Dr. William H. Lipman*, Kenosha, and *Dr. Walter H. Thiede*, Wauwatosa.

Surgery Society Elects

Dr. Donald E. Koepke and *Dr. John R. Pellett*, of the surgery department of the UW medical school, have been elected to membership in the Wisconsin Surgical Society. Both doctors are certified by the American Board of Surgery and the Board of Thoracic Surgery. They are assistant professors of surgery.

Ophthalmology Paper Published

An article entitled, "Diurnal Variation of Intraocular Pressure in the Normal Eye," by Dr. Guillermo de Venecia and *Dr. Matthew D. Davis*, of the surgery department of the UW medical school, was published in the June 1963 issue of the ARCHIVES OF OPHTHALMOLOGY.

Dr. Elizabeth Baldwin Speaks

Dr. Elizabeth Baldwin, city health officer of Marshfield, was the guest speaker at the July 10 meeting of the Woman's Society of Christian Service of the First Methodist Church. Doctor Baldwin addressed the group pertaining to women working outside of the home. She encouraged them to do so if at all possible, advocating the change from all home-life as invigorating.

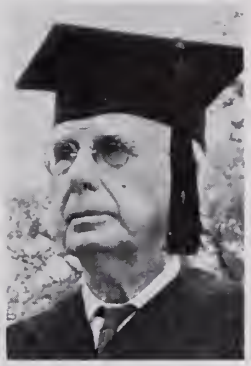
Assumes Locum Tenens for Dr. Kampine

Dr. J. A. Arana was a locum tenens for *Dr. C. E. Kampine*, Marathon, from July 1 until mid-August while the latter vacationed. Doctor Arana has a seven-year residency in obstetrics and gynecology and also does general practice. He is now senior resident at Milwaukee County Hospital.

Doctor Snodgrass a Speaker

Dr. H. M. Snodgrass, Janesville, was speaker at the annual picnic of the Second District Nurses Association held July 11 at the Pinehurst Sanatorium. His topic was "Geriatric Programs as Recognized Today."

W. J. McAweeney, M.D.



W. T. Clark, M.D.

Joins Jackson Clinic Staff

Dr. William J. McAweeney has joined the staff of the Jackson Clinic, Madison, in the department of internal medicine.

Doctor McAweeney graduated from the George Washington University School of Medicine, Washington, D. C. He served his internship at St. Vincent Hospital, Worcester, Mass., and served a two-year residency in internal medicine at St. Vincent Hospital and a one-year residency at the Lemuel Shattuck Hospital, Boston.

Beloit College Honors Doctor Clark

Dr. W. T. Clark, Janesville, was honored June 9 at the commencement exercises of Beloit college when he received the Distinguished Service Citation. He is shown above in cap and gown shortly before he received the honor. Doctor Clark, class of 1903, was one of six Beloit alumni cited for outstanding service to the community in their respective fields. Doctor Clark, a specialist in radiology, for several years was chairman of the State Board of Health in Wisconsin.

Doctor Hickey ACP Fellow

Dr. A. W. Hickey, of the La Crosse Clinic, was officially elected to fellowship in the American College of Physicians on November 17, 1962.

Society Section Officers for O–O

New officers for the SMS section of ophthalmology and otolaryngology elected at the annual meeting in May are: *Dr. Samuel S. Blankstein*, Milwaukee, chairman; and *Dr. Clemens Kirchgoorg*, Neenah, secretary.

OB–GYN Issues Certificates

On May 3 the American Board of Obstetrics and Gynecology issued certificates to the following Wisconsin physicians: *Dr. Paul E. Carroll* and *Dr. Claude W. Schmidt*, Waukesha; *Dr. William C. Fetherston*, *Dr. Howard I. Gass*, and *Dr. Samuel G. Perlson*, Milwaukee; *Dr. Eugene H. Raney*, Appleton; *Dr. John W. Rupel*, Marshfield; *Dr. Walter A. Scholten*, Beloit.

Cancer and the Dentist

Several Wisconsin physicians participated in the "Cancer and the Dentist" conference held July 24 at the University of Wisconsin, Madison. *Dr. A. R. Curreri*, of the Wisconsin medical school, reviewed "Research: 1963 Style," outlining government, university, and laboratory efforts in this area. Others who participated were: *Drs. Robert J. Samp*, program chairman; *Fred J. Ansfield, Robert O. Johnson, Sture A. M. Johnson, Wilhelm Klumper; Stanley L. Inhorn*, John R. Cameron, Ph.D., *John K. Scott, William H. Wolberg*, and *Frank D. Bernard*, all members of the UW medical school faculty. The UW department of surgery cancer research division and the Wisconsin division, American Cancer Society, co-sponsored the session. Dentists, dental technicians, and hygienists from midwest states heard discussions on developments in preventive, diagnostic, and therapeutic techniques for combating head and neck cancer, especially oral tumors. It is believed to be the first statewide professional conference of its kind.

Invitation from the

AMERICAN THORACIC SOCIETY

The Medical Section of the National Tuberculosis Association

The Medical Sessions Committee INVITES SUBMISSION OF PAPERS on all Scientific Aspects of Tuberculosis and Nontuberculous Respiratory and Cardio-Pulmonary Diseases for presentation at the 1964 ANNUAL MEETING IN NEW YORK CITY, MAY 25–27. Membership in the Society is not a prerequisite to participation on the program.

ABSTRACTS:

Abstracts of papers should be submitted before JANUARY 6, 1964, to the Chairman of the Medical Sessions Committee. Abstracts of papers from investigators outside the United States will be most welcome provided they are in English and are submitted with the understanding that all papers accepted must be presented in English at the Annual Meeting. All abstracts will be reviewed by the Medical Sessions Committee. Selection will be largely based on the areas of interest suggested by you and others receiving this invitation. Reports of interesting or unusual cases will be considered for inclusion in case conferences. Authors will be notified by FEBRUARY 10, 1964, if their papers have been accepted for presentation.

Abstracts selected for presentation at the Annual Meeting will be published in *The American Review of Respiratory Diseases.* Medical papers presented at the meeting may be submitted to *The American Review of Respiratory Diseases* by the author if he so desires for publication after the Annual Meeting.

PAPERS PRESENTED AT THE ANNUAL MEETING MUST BE ORIGINAL CONTRIBUTIONS NOT PREVIOUSLY PRESENTED OR PUBLISHED.

For further details contact: Robert Oseasohn, M.D., Chairman, Medical Sessions Committee, American Thoracic Society, 1790 Broadway, New York 19, N. Y.

Scientific Commission Organizes

At the June 27 meeting of the Commission on Scientific Medicine, held at Society headquarters in Madison, the following assignments were given the members in preparing the program for next year's annual meeting of the Society. *Dr. A. R. Curreri*, Madison, was named chairman; *Dr. P. T. Bland*, Westby, general chairman for the annual meeting; *Dr. G. E. Collentine*, Milwaukee, luncheons; *Dr. J. K. Curtis*, Madison, scientific exhibits; and *Dr. T. V. Geppert*, Madison, as the newest member of the Commission, will handle special assignments.

The 1964 annual meeting has been scheduled for Monday, Tuesday, and Wednesday, May 11–13.

New Children's Hospital Wing Opened

The newly remodeled South Wing of the Children's Hospital at University Hospitals, Madison, was opened July 15 after nine months of remodeling which cost $235,000. There are four floor levels; the top floor is now occupied by the Joseph P. Kennedy, Jr. Laboratories.

New Doctors at Tomah VA Hospital

Two new physicians were added July 1 to the medical staff of the Tomah VA Hospital. They are Dr. Thomas A. Phillips and Dr. Nathaniel O. Calloway. Doctor Phillips was born in Great Britain. He received his M. D. degree in December 1956 from the School of Medicine of the University of Birmingham, England. He came to the United States in 1961 and held the position of staff physician at the Abilene State School, Abilene, Texas. He has recently completed his residency training in psychiatry at the Central State Hospital, Petersburg, Va. Doctor Phillips is assigned to the Psychiatric Service.

Doctor Calloway was born in Tuskegee, Ala. He attended the University of Chicago and University of Illinois, receiving his M. D. degree in 1943. He has had wide experience in teaching, administration, research and private practice with a special interest in internal medicine and chemistry. He has been a consultant to several drug corporations. Doctor Calloway is Chief of the Medical Service at the Tomah hospital.

Fetal Hearts From Mount Sinai Transmitted to Paris Via Relay Satellite

Electrical impulses from the hearts of a Milwaukee woman and her unborn child were transmitted from Mount Sinai Hospital, Milwaukee, to Paris, France, by way of relay satellite on May 28.

This pioneering project was made under the direction of *Dr. Alvin Kurzon* of the Mount Sinai medical staff and Dr. Saul Larks, professor of bio-medical engineering at Marquette University, through the facilities of the National Aeronautics and Space Administration.

The heartbeats of the unborn child and its mother, Mrs. Donna Lee Thomas, Milwaukee, were heard in Paris by Dr. Antoine Remond, president of the International Federation for Medical Electronics. According to authorities, this was the first time a transmission of such a small signal has been transmitted through the relay satellite. The purpose of the experiment was to determine whether the tiny electrical signal from the fetal heart—about 25 millionths of a volt—could undergo the conversions necessary for satellite transmission and still maintain its fidelity.

According to Doctor Kurzon, fetal electrocardiography is useful in detecting fetal life as early as 10½ weeks, in revealing multi-pregnancies, establishing the position of the unborn child and determining the effects of various drugs used in delivery on the unborn child.

Doctor Larks stressed the importance of rapid, round-the-world transmission of medical information.

"For example, when the effects of thalidomide were first suspected," he said, "physicians in many countries could have been alerted if high speed communication between medical authorities were an established procedure."

The National Aeronautics and Space Administration controls the Relay I communications satellite which is capable of carrying 500 transmissions simultaneously. It was developed and is operated by the NASA Goddard Space Flight Center, Greenbelt, Md.

The heartbeats of an unborn child at Mount Sinai Hospital, Milwaukee, were transmitted to Paris, France, via this communication satellite developed by the National Aeronautics and Space Administration. This eight-sided prism weighs 172 pounds, is 33 inches high and 29 inches in diameter at its broad end. The exterior is composed of eight honeycomb aluminum panels studded with 8,215 solar cells. Designed for technical experiments, television, telephone calls, teletype photo facsimiles and high speed data will be transmitted by the satellite.

On May 17, fetal heartbeats were transmitted from Mount Sinai to Paris by transoceanic telephone.

Both the experiments were widely covered by local press, radio and television.

SHACKLES . . . HOBBLING . . . COLLECTIVISM

Our own American profession well can learn the lesson . . . It is but little more important to maintain the freedom of the medical profession than to insist on the freedom of our hospitals from the shackles of government control, and the hobbling of the pharmaceutical industry by unduly restrictive legislation. In fact, all must be free or all will be subjected to collectivism. We should be as watchful for any significant signs of surrender to government pressures on the part of the American Hospital Association and the Pharmaceutical Manufacturers Association, as we are for the safety of our own freedom; and we should fight as hard for their freedom as we do for our own.—Editorial in *Nebraska State Medical Journal*, January, 1963.

Medical School Graduates Trained in Far Off Madagascar and South Vietnam

Two 1963 graduates of Wisconsin's medical schools have capped their formal medical training by broadening their clinical knowledge and skills far from the immaculate wards, sterile surgeries, and well-equipped diagnostic laboratories of their homeland.

Dr. Catherine Condon, a graduate of the School of Medicine of Marquette University, assisted at a shorthanded mission clinic-dispensary high in the central plateau region of wartorn South Vietnam, while Dr. David A. Mathison, graduate of the University of Wisconsin Medical School, extended his training at a mission hospital on the far off island of Madagascar.

Doctor Condon and Doctor Mathison were among 33 recipients of Smith Kline & French Laboratories Foreign Fellowships for Medical Students awarded last year by the Association of American Medical Colleges. Both went abroad during the second half of their senior year.

Under the direction of an American woman physician, Doctor Condon helped the Mission Catholique at Kontum to provide a measure of medical care to the primitive, poverty-stricken tribal people of the Vietnamese uplands. Doctor Condon participated in all the activities of the clinic-dispensary and journeyed with her sponsor, Dr. Patricia Smith, to outlying villages to attend to the medical needs of the unfortunate Montagnards caught in the toils of war and poverty and their inevitable corollaries—malnutrition and disease.

Doctor Mathison, who was accompanied by his wife, Gail, a public health nurse, spent 11 weeks at the Hopitaly Loterana at Manambaro near the southern tip of the island of Madagascar, a former French colony, like South Vietnam, and now an independent nation known as the Malagasy Republic. Doctor Mathison is from Milwaukee, and Mrs. Mathison from Whitefish Bay.

Enroute to the village of Plei–Krong in South Vietnam, the mission's ambulance is flagged down near another village. Dr. Patricia Smith holds a child while Dr. Catherine Condon conducts an examination.

Dr. Dovid A. Mathison with his sponsor, Dr. Alf E. Borge, during ward rounds at Hopitaly Loterana, island of Madagascar.

Hopitaly Loterana is a 50-bed general hospital serving an area with a population of about 100,000. Under the direction of their sponsor, Alf F. Borge, M. D., the Mathisons helped in most of the activities of the hospital. Each day, for Doctor Mathison, there were ward rounds, from 50 to 100 patients to be seen in the outpatient clinic and perhaps one, two or three operations to assist with in the surgical theater. Mrs. Mathison, meanwhile, helped to prepare a public health program and assisted in the wards and surgery.

The basic medical needs on Madagascar, as in every other developing nation, lie in the fields of public health and preventive medicine, according to Doctor Mathison. He cited the Malagasy government's anti-tuberculosis program as one of the ways the new nation is struggling to improve the health of its people. The mission, he said, is helping with this and other public health programs.

Both Doctor Condon and Doctor Mathison have entered intern training, Doctor Condon at Los Angeles County Hospital, Los Angeles, California, and Doctor Mathison at the University of Rochester Hospital, New York.

This year, Wisconsin is represented in the Smith Kline & French program by two more students. They are Dr. Donald Wong, a graduate of the Marquette School of Medicine, who is assisting at a rural hospital on Formosa, and Richard C. Reznichek, a resident of Madison and a senior at the Northwestern University Medical School, who assisted at a MEDICO outpost in Cambodia.

OBITUARIES

Dr. George A. Steele, Oshkosh, died January 14, 1963, at the age of 80.

A native of Oshkosh, Doctor Steele was a 1909 graduate of Marquette University School of Medicine, and served his internship at St. Vincent's Hospital, Green Bay.

After practicing in Redgranite, Wis., from 1910–1917, Doctor Steele located in Oshkosh, where he practiced continuously until his death. Prior to receiving his medical education, he taught in rural schools of Brown County from 1901–1905. During his more than 50 years of practice, Doctor Steele served in various capacities including an aviation examiner for civil defense from 1928 to 1956.

In 1960, Doctor Steele was elected to the 50-Year Club of the State Medical Society of Wisconsin. He was also a member of the Winnebago County Medical Society and the American Medical Association.

Survivors include his widow, Edna; and one daughter, Mrs. Charles Boschi, Freeport, Ill.

Dr. Rolla U. Cairns, River Falls physician for over 50 years, died January 16, 1963, at the age of 88.

Born in Ellsworth, Wisconsin, Doctor Cairns was a 1902 graduate of the Northwestern University Medical School. He immediately established his practice in River Falls. In 1910, he interrupted his private practice to take specialized training in eye, ear, nose, and throat in Vienna. Upon completion of his training he returned to River Falls, and in 1952 was honored by the State Medical Society for his 50 years of service to that community.

Doctor Cairns was instrumental in establishing the Wisconsin Anti-Tuberculosis Association, and in 1910 was appointed to the State membership committee. He was also active in the Pierce County Historical Circle, and had a wealth of information on the early history of the county. He was a member of the Pierce-St. Croix Medical Society, and had served as an officer of that county society many times; a member of the State Medical Society of Wisconsin, and a former Council member; and a member of the American Medical Association.

Surviving are his widow, Violet; his son, Lloyd of Mauston; and two daughters, Miriam Wilke, Waukesha; and Elva Norris of Wheaton, Ill.

Dr. John A. Cox, Milwaukee eye, ear, nose, and throat specialist, died February 1, 1963, at the age of 77.

Born in Greenleaf (Brown County), Wis., Doctor Cox was graduated from the Oshkosh normal school in 1907. He taught school in Sussex, Wis. prior to entering the Marquette University School of Medicine from which he received his medical degree in 1912. After practicing in Kaukauna from 1912 to 1917, he located at Wautoma until 1924 after which he went to the University of Vienna to receive specialized training in eye, ear, nose, and throat. Upon completion of this training, Doctor Cox located in Milwaukee, where he practiced until his death.

He was a member of the State Medical Society of Wisconsin, and in 1962 was honored by them for 50 years of medical practice; a member of the Medical Society of Milwaukee County and the American Medical Association.

Surviving are a son, Dr. Thomas Cox, Whitefish Bay; four daughters, Mrs. Steven Keane, Shorewood; Mrs. Robert Smith, Freeport, Ill.; Mrs. Robert Stemper, Wauwatosa, and Mrs. Michael Gonring, Jr., West Bend.

Dr. Sidney B. Russell, 61, a prominent Eau Claire physician, died at his home February 7, 1963.

A native of Calumet, Mich., Doctor Russell had practiced medicine in Eau Claire for over 25 years. Prior to his location there, he practiced for one year at St. Paul, Minn. He received his medical degree from the University of Minnesota; his internship and residency were served at St. Mary's Hospital, Minneapolis.

An eye, ear, nose, and throat specialist, Doctor Russell was a member of the American College of Surgeons, the American Academy of Ophthalmology and Otolaryngology; served on the Division of Visual and Hearing Defects, and on the subcommittee on Ear, Nose and Throat. In addition to his practice, Doctor Russell was a lecturer at the nursing school at Luther Hospital in Eau Claire. He also held membership in the Eau Claire-Dunn-Pepin County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Elizabeth; two daughters, Mrs. Paul Smith, and Mrs. Hans Grillmann, both of Lafayette, Ind.

Dr. Edgar F. Andre, Kenosha physician for 32 years, died February 12, 1963, at the age of 58.

A native of Kenosha, Doctor Andre received his medical education at Marquette University School of Medicine, graduating in 1931. He interned at St. Paul's Hospital, Dallas, Tex., after which he located in Kenosha where he practiced continuously until his death.

In addition to being active in civic affairs, Doctor Andre had served as secretary of the Kenosha County Medical Society, and was an active member of the staffs of Kenosha Hospital and St. Catherine's Hospital at Kenosha. Doctor Andre was a member of the State Medical Society of Wisconsin, the American Medical Association, the American Academy of General Practitioners, and the American Society of Physicians and Surgeons.

Doctor Andre is survived by his widow, Marie.

Walter J. Meek, Ph.D., 84, former acting dean of the University of Wisconsin Medical School and a faculty member at the University for 41 years died February 15, 1963, at Ft. Myers Beach, Florida.

Born in Dillon, Kan., Doctor Meek received his B. A. from the University of Kansas in 1902, his M. A. from Penn College, Iowa in 1907, where he carried additional duties as professor of biology. In 1909 he received his Ph.D. from the University of Chicago, and at that time came to Wisconsin as an instructor in physiology. He became an assistant professor in physiology at the University of Wisconsin in 1910, an associate professor in 1912 and a full professor in 1918. In 1920, he was made assistant dean of the medical school, and from 1942 to 1945, while Doctor Middleton, the dean, was in service, he took on the extra task of acting dean.

Doctor Meek served as a major in the Chemical Warfare Service in World War I; he was president of the American Physiological Society from 1929 to 1932; in 1946, he was chairman of the Research Committee of the University of Wisconsin. He was an honorary member of the State Medical Society of Wisconsin, and received its Man of the Year award in 1944; a member of the National Academy of Sciences, the Society of Experimental Biology and Medicine, and Phi Beta Kappa.

Survivors include his widow; a son, John, professor of chemistry at the University of Colorado, and a daughter, Mary.

Dr. Donald W. Curtin, well-known Kimberly physician, died March 17, 1963, at the age of 61.

A native of Hollandtown, Doctor Curtin received his medical degree from Marquette University School of Medicine in 1929. He interned and served a one-year surgical residency at Milwaukee County General Hospital. Doctor Curtin practiced a short time in Milwaukee before locating in Kimberly in 1933, where he continued his practice for over 30 years.

In addition to membership in the State Medical Society of Wisconsin, the Outagamie County Medical Society, and the American Medical Association, Doctor Curtin held membership in the American Society of Industrial Physicians, the Central Society of Industrial Physicians, and the American Academy of General Practice.

He is survived by his widow, Dorothy; two sons, Jeffrey, Kimberly; and Donald, Jr., at home; two daughters, Katie, Milwaukee, and Cissy, at home.

Dr. Cyril F. Turney, Milwaukee, died March 25, 1963, at the age of 79.

Born in Barbados, B. W. I., Doctor Turney was educated at the Meharry Medical School in Tennessee. He located in Milwaukee after practicing in Americus, Ga., from 1919 to 1925. He practiced continuously in Milwaukee until 1956, at which time he semi-retired because of ill health.

Doctor Turney was a member of the State Medical Society of Wisconsin, the Medical Society of Milwaukee County, and the American Medical Association.

Surviving are his widow, Lauretta; and two daughters, Mrs. Viola Wood and Mrs. Matt Teague.

Dr. Merlin C. Briggs, Milwaukee, died April 11, 1963, at the age of 42.

Born at Redgranite, Wis., Doctor Briggs moved to Milwaukee as a child and received his medical education at Marquette University School of Medicine, graduating in 1951. He completed his internship at St. Luke's Hospital, Milwaukee, in 1952, and was a staff member at St. Luke's prior to joining the Krohn Clinic at Black River Falls in August of that year. In 1953, Doctor Briggs relocated in Milwaukee, and had been engaged in general practice there since that time.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Jean; four children, Robert, James, Janice, and JoAnn, all at home.

Dr. Joseph A. Kelly, retired Chippewa Falls physician, died April 13, 1963, at the age of 75.

Born in Appleton, Wis., Doctor Kelly received his medical degree from Marquette University School of Medicine in 1913. He then practiced in Northwest Colorado for two years prior to his enlistment into service during World War I. In 1919, Doctor Kelly located in Chippewa Falls, and was physician and surgeon at the Northern Wisconsin Colony and Training School until 1929. At that time, he entered private practice in Chippewa Falls, and continued until 1949, when he became head physician at Northern Wisconsin Colony, the position which he held until his retirement in 1962.

Doctor Kelly was coroner in Chippewa Falls until 1948; he also was appointed city health officer, and held this position until 1948.

Surviving is his widow, Lois.

Dr. John J. Kazmierowski, Milwaukee physician, died April 15, 1963, at the age of 73.

A 1915 graduate of Loyola University Medical School, Doctor Kazmierowski had practiced medicine in Milwaukee for over 20 years.

He is survived by his widow, Emily.

Dr. Eugene L. Dallwig, Milwaukee surgeon, died April 20, 1963, at the age of 74.

Born in Milwaukee, Doctor Dallwig, was a 1916 graduate of Washington University, St. Louis, Mo. He interned at Barnes Hospital in St. Louis, and completed his internship and served his surgical residency at Augustana Hospital, St. Louis.

Doctor Dallwig served in the Medical Corps from 1918 to 1919, at which time he located in Milwaukee.

He was a member of the International College of Surgeons, the Wisconsin Academy of Surgery, the State Medical Society of Wisconsin, the Medical Society of Milwaukee County and the American Medical Association.

Survivors include his widow, Irma; and son, Eugene, Jr.

Dr. Jeremy J. Sharpe, Fond du Lac physician for over 40 years, died April 30, 1963, at the age of 74.

A native of Highmore, S. D., Doctor Sharpe was a 1915 graduate of the University of Illinois College of Medicine and Surgery at Chicago. He received his residency training in the Navy; and upon completion of his military service in 1920, located at Fond du Lac, where he practiced until his death.

Doctor Sharpe was a member of the Central Wisconsin Eye, Ear, Nose, and Throat Association; the Fond du Lac County Medical Society; the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow; a son, Joseph, Springfield, Ill.; and two daughters, Mrs. Converse Hettinger, Washington, D. C., and Mrs. Allen Filbey, Walled Lake, Mich.

Dr. Claude F. Schroeder, Milwaukee physician, died May 3, 1963, at the age of 57.

A native of Two Rivers, Doctor Schroeder was a 1933 graduate of the University of Wisconsin Medical School. After serving his internship at St. Joseph Hospital, Kansas City, Mo., he practiced for four years at Amherst, Wis. In 1939, he located in Princeton, Wis., where he remained until joining the staff of the Jackson Clinic, Madison, in 1944. In 1960, Doctor Schroeder moved to Milwaukee where he became an allergy specialist on the staff of the Veterans Administration Hospital at Wood.

He was a member of the American College of Allergists, the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Adella; a daughter, Claudia, of Waltham, Mass.; a son, Thomas, Milwaukee, and his mother of Two Rivers.

Dr. Herman A. Aageson, prominent Oconto physician for 22 years, died July 3, 1963, at the age of 59.

A native of Leeds, North Dakota, Doctor Aageson graduated from the University of North Dakota and received his medical degree from Rush Medical School, now the University of Chicago. His internship and residency training in surgery were served at Milwaukee County Hospital. Upon completion of his studies in 1941, Doctor Aageson located in Oconto.

Doctor Aageson was extremely active in civic affairs in Oconto, as well as serving on many professional committees. He was past president and current secretary of the Oconto County Medical Society; a member of the Commission on Medical Care Plans of the State Medical Society of Wisconsin; and a member of the American Medical Association.

Surviving are his widow, Clarice; two daughters, Sheila and Christine, at home; a son, Thomas, Milwaukee; his father, Thomas, St. Cloud Minnesota; a brother and three sisters.

EDITORIAL

Reprinted with permission from the MARINETTE EAGLE-STAR, July 8, 1963

Dr. H. A. Aageson Served His Community

The shock of Dr. H. A. Aageson's untimely death at the mature prime of his service is only now giving way to full recognition of the loss Oconto has suffered. In 22 years of diligent professional and civic service, he made a niche in the community which will be remembered for years to come.

Evidence of the high regard in which he was held was shown by the closing Friday of many Oconto business places so that their employes could attend funeral services at St. Joseph's Church. Classmates from all over the state came to pay their final respects and 20 doctors of the area served as honorary pallbearers. An honor guard was formed by 40 uniformed registered nurses, practical nurses, aides and other hospital personnel. The church was filled to overflowing and those who could not find a place inside stood in the streets during final rites for the beloved physician.

Dr. Aageson himself didn't indulge in tooting his own horn; he preferred to work quietly and efficiently at caring for his patients and restoring them to health as quickly as possible. Many felt that his energy and cheerful disposition were like a tonic and these qualities of his personality made him a favorite with the nurses at Oconto Hospital, too.

He became known through the community as "Aagie" and, although his work-load was heavy, he always seemed to find time to chat a few minutes, tell one of his latest stories or sip a cup of hot, black coffee. His day began with the first call for his services and ended when all of his patients had been attended. "Aagie" was smalll in stature but big in vitality and his ability to extend it widely.

He came to Oconto to replace Dr. Al Tousignant during World War II and immediately was caught in a whirl of professional activity that left him little time for social events and recreation. When he could find time for it, he enjoyed hunting and fishing.

Oconto already feels a sense of loss in the disappearance of Dr. Aageson's trim, neatly dressed figure from the streets but even more it will regret the loss of his competent services. His patients and his family can tell how much.

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The muscle relaxant properties[2] of this drug provide an extra dimension of effectiveness...relaxing the spasm which so frequently accompanies psychogenic disorders. Hence, the total therapeutic effect of TRANCOPAL (chlormezanone/Winthrop)—a true "tranquilaxant"—is to produce a relaxed mind in a relaxed body.

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References: 1. A.M.A. Council on Drugs J.A.M.A. 183:469 (Feb. 9) 1963. 2. Gruenberg F.: Curr. Ther. Res. 2:1 (Jan.) 1960.

SOCIETY RECORDS

NEW MEMBERS

J. L. Bramschreiber, 205 East Walnut Street, Green Bay.
Richard J. Bukosky, 327th USAF Hospital, Truax Field.
Diane A. Dahl, Northern Wisconsin Colony, Chippewa Falls.
Paul J. Fitzpatrick, 434 East Fremont Place, Milwaukee.
E. Paul Gander, 417 Milwaukee Avenue, Burlington.
Carl C. Kobelt, 601 Reed Avenue, Manitowoc.
Sanford Mackman, 1122 Alrita Court, Madison.
Mahmood Mirhoseini, Athens.
Earl J. Roth, 606 Superior Street, Antigo.

CHANGES OF ADDRESS

Jack G. Anderson, 424 East Longview Avenue, Appleton.
J. M. Beffel, Milwaukee, to 2837 North 98th Street, Wauwatosa.
Louis A. Bernhard, 6036 West Kaul, Milwaukee 18.
Robert L. Bolton, 829th Medical Group, Larson AFB, Wash.
J. W. Bookhamer, Milwaukee, to 2450 Swan Boulevard, Wauwatosa.
Blaine W. Claypool, Jr., 1602 North Meade Street, Appleton.
W. A. Dafoe, 1602 North Meade Street, Appleton.
Ettore Dimiceli, Jr., Elm Grove, to 161 North 90th Street, Milwaukee 13.
E. C. Eickhoff, Bozeman, Mont., to Land O' Lakes Clinic, Land O' Lakes.
Leslie Fai, 8104 22nd Avenue, Kenosha.
F. M. Frechette, 1 East Milwaukee Street, Janesville.
Robert B. Fruchtman, 3975 North 68th Street, Milwaukee.
Francis Gilbert, 403 North Grand Avenue, Waukesha.
C. R. Gilbertsen, 1 East Milwaukee Street, Janesville.
Alfred E. Graf, 5625 Washington Avenue, Racine.
Donald E. Gunderson, Wauwatosa, to 4586 Patron Court, Cincinnati 38, O.
Holly H. Heitzman, R. #7, Country Club Road, Green Bay.
Anthony A. Herrmann, 6515 Charles Street, Racine.
Bernard F. Kalina, Green Bay, to 39 Carrier Street, Liberty, N. Y.
Paul E. Kaschel, Antigo, to 535 North 105th Street, Milwaukee.
Julius N. Kelertas, Eau Claire, to Northern Wisconsin Colony, Chippewa Falls.
John A. Malone, Cudahy, to 3046 South 13th Street, Milwaukee 15.
C. L. Meyers, 412 East Longview Avenue, Appleton.
Leroy Mitcham, 2549 North Third, Milwaukee.
William H. Nicolaus, 152 Custer Court, Green Bay.
Carlyle R. Pearson, Box 169, Baraboo.
Eugene F. Pischke, Box P, Baraboo.
Maurice J. Reuter, Jr., Appleton, to 2312 West Capitol Drive, Milwaukee.
Edward P. Roemer, Madison, to 1194 Oxford Road, San Marino, Calif.
F. N. Roemhild, Watertown, to Prairie Farm.
M. S. Saydjari, Barron, to Wetumka, Okla.
W. E. Scheunemann, 128 North Main Street, West Bend.
Raymond Schofield, 16837 West Greenfield, New Berlin.
George J. Schroth, Medical Arts Building, Wausau.
Elvira C. Seno, Downey, Ill., to 301 Troy Drive, Madison 4.
George C. Shonat, Chippewa Falls, to 2304 East Oakland Avenue, Bloomington, Ill.
Darrell R. Slette, 103 West College Avenue, Appleton.
Elaine M. Thomas, Milwaukee, to 150 South Calhoun Road, Brookfield.
Peter Torbey, Madison, to Sahlgrenska, Gothemberg, Sweden.
Heinz Vogel, Madison, to 6629 Maywood Avenue, Middleton.
G. R. Weber, 6334 Third Avenue, Kenosha.
Stephen Wojcechowskyj, 7031 Aetna Court, Milwaukee 13.
Frank Wright, Jr., 412 East Longview Avenue, Appleton.

REMOVED FROM MEMBERSHIP

Charles E. Elson, Waukesha county, transferred to Illinois.
Walter R. Hathaway, Winnebago county, transferred to Iowa.
John R. Jones, Milwaukee county, transferred to Nebraska.
Russell M. Maynard, Milwaukee county, transferred to Arizona.
Walter L. Modaff, Milwaukee county, transferred to Iowa.
Lewis J. Weller, Pierce-St. Croix county, transferred to Oregon.

DEATHS

John T. Klein, Milwaukee, Milwaukee county, May 29, 1963.
Wilbert A. Adrians, Appleton, Outagamie county, May 30, 1963.
Robert W. Kispert, Green Bay, Brown county, June 13, 1963.
Edward C. Jarvis, Tomahawk, Lincoln county, May 24, 1963.
Thomas C. Proctor, non-member, May 22, 1963.

W. B. SAUNDERS COMPANY

features the following new editions in their full page advertisement appearing elsewhere in this issue:

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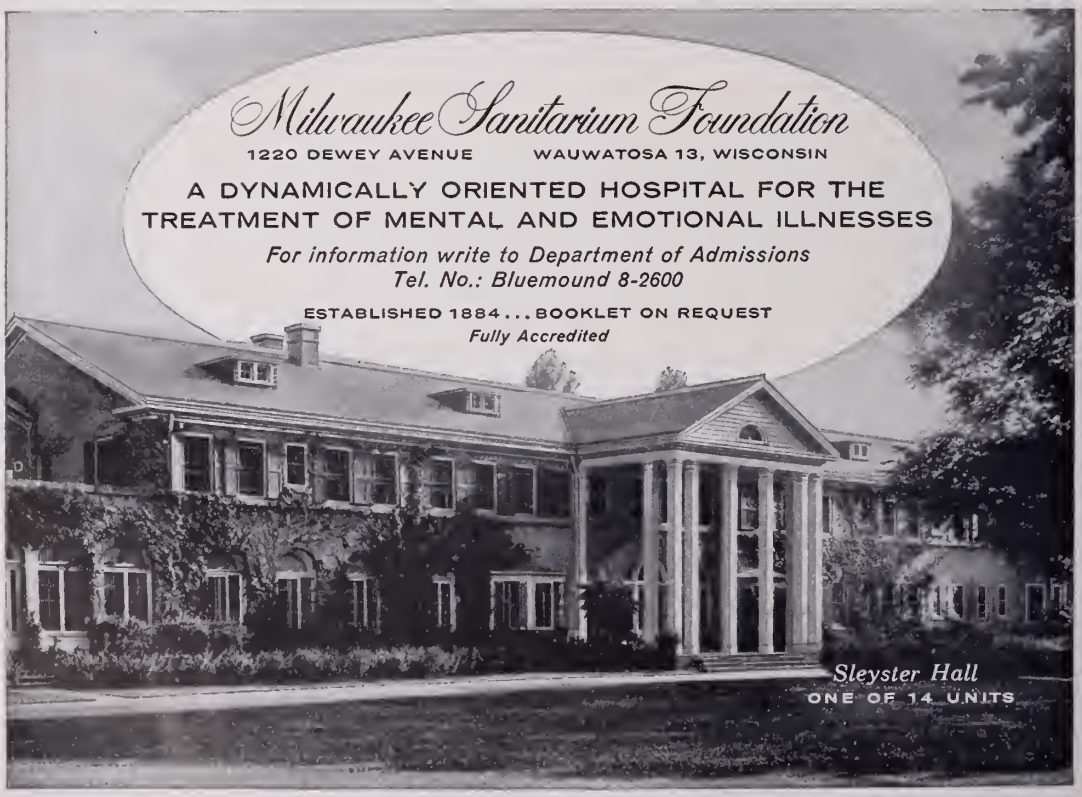

1963 **Wisconsin**

Sept. 13–14: Fall meeting, Wisconsin Society of Internal Medicine, Leathem-Smith Lodge, Sturgeon Bay.

Sept. 13–14: Fall meeting, Wisconsin Surgical Society, Deer Park Lodge, Manitowish Waters.

Sept. 13–15: Annual meeting, Wisconsin Radiological Society, Maxwelton Braes Country Club, Bailey's Harbor.

Sept. 14: Institute on Management of the Mentally Retarded and Underfunctioning Child in School and Community, University of Wisconsin, Wisconsin Center, Madison.

Oct. 2: Jackson Clinic–Marquette Medical school clinic day, at Jackson Clinic, Madison.

Oct. 2–4: Annual convention, Wisconsin Nurses Association, Hotel Schroeder, Milwaukee.

Oct. 12: Ninth Annual Fall Cancer Scrimmage, University of Wisconsin Medical Center, Madison, sponsored by the Division of Clinical Oncology, UW, and the Wisconsin Division of the American Cancer Society.

Oct. 20–23: Annual District VI meeting of American College of Obstetricians and Gynecologists, Milwaukee.

Oct. 30-31 & Nov. 6: 1963 Clinical Advances and Review, Mount Sinai Hospital Staff, Milwaukee.

Nov. 20–21: Third annual Milwaukee Medical Conference, at Milwaukee County Hospital, sponsored by the Medical Society of Milwaukee County.

Nov. 21: Eberbach Memorial lecture honoring Milwaukee Hospital centennial, by Dr. Carl E. Badgley, professor of orthopedic surgery, University of Michigan School of Medicine, Milwaukee.

Nov. 22: All-day symposium on Industrial Back Injuries, Mount Sinai Hospital, Milwaukee.

1964

Feb. 24–29: Wisconsin Work Week of Health, State Medical Society Headquarters, Madison.

Apr. 2–3: Annual Meeting, Wisconsin Anti-Tuberculosis Association, Coach House Motor Inn, Milwaukee.

Apr. 4: Annual Meeting, Wisconsin Thoracic Society (WATA medical section), Coach House Motor Inn, Milwaukee.

May 11–13: Scientific program of Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

1963 **Out-of-State**

Sept. 14–15: Course in Radiology, College of Medicine, State University of Iowa, Iowa City.

Sept. 16–28: Course in Laryngology and Bronchoesophagology, Dept. of Otolaryngology, University of Illinois College of Medicine, Chicago.

Sept. 17–19: Fifth National Cancer Conference, American Cancer Society and National Cancer Institute, Bellevue-Stratford Hotel, Philadelphia, Pa.

Sept. 18–19: Course in Pediatrics, College of Medicine, State University of Iowa, Iowa City.

Sept. 20–21: National Rural Health Conference, Council on Rural Health of the AMA, Hot Springs, Ark.

Sept. 22–27: Annual Meeting, Michigan State Medical Society, Grand Rapids.

Sept. 25–26: National Congress on Occupational Health, AMA's Council on Occupational Health, San Francisco, Calif.

Oct. 9–13: Annual Meeting, American Association of Medical Assistants, Miami Beach, Fla.

Oct. 10–13: Annual Meeting, American Society of Clinical Hypnosis, San Francisco, Calif.

Oct. 11: Course in Diagnostic Techniques in Office and Surgical Urology, College of Medicine, State University of Iowa, Iowa City.

Oct. 12–13: Annual meeting, The Mid West Allergy Forum, Sheraton-Cleveland Hotel, Public Square, Cleveland, Ohio.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, sponsored by the Council on International Affairs of the American College of Chest Physicians, Mexico City.

Oct. 13–19: XVIIth World Medical Assembly (originally scheduled in Mexico City Sept. 22–28), Commodore Hotel, New York City.

Oct. 14–18: Course in Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, International Inn, Washington D. C., American College of Chest Physicians.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Oct. 14–18: Course in Sources and Use of Toxicological Information, Institute of Industrial Medicine, New York University Medical Center, Onchiota Conference Center, Tuxedo, N.Y.

Oct. 16–19: Conference on Obstetric, Gynecologic and Neonatal Nursing, sponsored by District VI, American College of Obstetricians and Gynecologists, Chicago.

Oct. 18: Course in Arthritis and Rheumatism, College of Medicine, State University of Iowa, Iowa City.

Oct. 21–22: 1963 Scientific Session of American Cancer Society—A conference on "Unusual Forms and Aspects of Cancer in Man", Biltmore Hotel, New York City.

Oct. 21–24: Interstate Postgraduate Medical Assembly, scientific program, Chicago.

Oct. 21–25: Course in Clinical Cardiopulmonary Physiology, American College of Chest Physicians, Pick Congress Hotel, Chicago.

Oct. 22–24: Course in Fractures in General Practice, Medical College of Georgia, Augusta.

Oct. 23–25: Chiefs-of-staff Conference, University of Colorado Medical Center, Denver.

Oct. 24–26: Course in Postgraduate Gastroenterology, American College of Gastroenterology, Washington, D. C.

Oct. 25–26: Second National Congress on Medical Quackery, Sheraton–Park Hotel, Washington, D. C.

Oct. 25–27: Annual scientific sessions of the American Heart Association Biltmore Hotel, Los Angeles, Calif.

Oct. 27–Nov. 1: Annual clinical congress, American College of Surgeons, Chicago, Ill.

Oct. 28–Nov. 1: Course in Allergy and Hypersensitivity States sponsored by the American College of Physicians, at Northwestern University Medical School.

Oct. 28–Nov. 1: Annual Clinical Congress of the American College of Surgeons, San Francisco, Calif.

Oct. 30–Nov. 2: Twelfth Biennial Rocky Mountain Medical Conference, sponsored by seven Rocky Mountain state medical societies, at Las Vegas, Nev.

Nov. 5–13: Ninth Congress of the Pan–Pacific Surgical Association, Honolulu, Hawaii.

Nov. 11–15: Course in Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Barbizon Plaza Hotel, New York City.

Nov. 13–Dec. 10: First Pan–Pacific Mobile Educational Lecture Seminar, New Zealand, Australia, Thailand, the Philippines, Hong Kong and Japan.

Nov. 15: Seventh Annual Symposium on Diabetes at the A. B. Dick Amphitheatre, Presbyterian-St. Luke's Hospital, Chicago, sponsored by the Diabetes Association of Greater Chicago.

Nov. 18–20: Scientific meeting of the Ophthalmology and Otolaryngology Section of the Southern Medical Association, New Orleans, La.

Nov. 18–21: Annual meeting of the Southern Medical Association, New Orleans, La.

Nov. 21–23: First Sectional Meeting (Midwest) of the American College of Physicians, Detroit, Mich.

Nov. 22–25: Annual convention, National Society for Crippled Children and Adults, Palmer House, Chicago.

Nov. 23: Annual meeting, American Rhinologic Society, Illinois Masonic Hospital, Chicago.

Dec. 2–6: Course in Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Ambassador Hotel, Los Angeles.

1964

Jan. 5–8: First Annual Postgraduate Seminar in Anesthesiology, Miami Beach, Fla., sponsored by the University of Miami and University of Florida schools of medicine.

Jan. 9–11: International Symposium on Anticoagulant Therapy in Ischemic Heart Disease sponsored by Miami Heart Institute at Fontainebleau Hotel, Miami Beach, Fla.

Jan. 13–17: Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Hotel Fontainebleau, Miami Beach.

Feb. 17–19: Canadian-American Medical and Dental Ski Association meeting, Harbor Highlands, Harbor Springs, Mich. Sec-Treas: T. J. Trapasso, M.D., 816 Ashmun St., Sault Ste. Marie, Mich.

May 11–14: Annual scientific meeting, Aerospace Medical Association Americana Hotel, Bal Harbour, Miami, Fla.

May 25–27: Annual meeting, American Thoracic Society, medical section of the National Tuberculosis Association, New York City.

June 15–19: Postgraduate course in Psychiatry for Internists, sponsored by the American College of Physicians, at Psychiatric Institute and the General Hospital of the University of Maryland School of Medicine.

Mount Sinai Hospital Symposium

An all-day symposium on industrial back injuries will be presented at Mount Sinai Hospital, 948 N. 12th St., Milwaukee, on Friday, November 22. The meeting is sponsored by the orthopedic section of the Mount Sinai medical staff. Dr. David J. Ansfield is chairman of the program which will feature a noted group of medical and legal authorities.

Appearing on the program will be: Dr. Alexander Aitken, Boston; Attorney Edward Borgelt, Milwaukee; Ralph Gintz, director of Workmen's Compensation for the State of Wisconsin; the Honorable George Currie, Justice of the Wisconsin Supreme Court; Attorney Lawrence Gillick, Milwaukee; Dr. Earl McBride, Oklahoma City, Okla., and Dr. Alfred Uihlein, Mayo Clinic, Rochester, Minn.

Invitations will be sent to members of the medical, nursing, and legal professions as well as to industry and the Wisconsin Safety Council. Others wishing to attend may call the medical office at Mount Sinai Hospital.

American Rhinologic Society

The ninth annual meeting of the American Rhinologic Society will be held at the Illinois Masonic Hospital, Chicago, November 23. The program will consist of panel and individual presentations of "Many Practical Aspects of Rhinologic Surgery."

Preceding the meeting, there will be a two-day surgical seminar directed to those with a moderate or advanced experience. There will be a dinner, fellowship hour and preliminary discussions in the evening (November 20) before the opening of the seminar.

For further information, write to George H. Drumheller, M.D., Secretary, American Rhinologic Society, 1515 Pacific Avenue, Everett, Washington.

Medical College of Georgia

The Medical College of Georgia, Department of Continuing Education, has planned a series of five postgraduate courses for the fall and winter 1963–64. These are:

Psychosomatic Medicine Conferences. 12 weekly sessions beginning October 9, 1963, Wednesday evenings, 7:30–9:00.

Fractures in General Practice, October 22–24, 1963; *Guest Faculty:* Walter P. Barnes, Jr., M.D., Orthopedic Surgeon, Macon, Ga.; D. Keith McElroy, M.D., Asst. Clin. Professor of Surgery (Orthopedics), Columbia Presbyterian Medical Center, New York, N. Y.

Thirteen Cardiacs, January 14–16, 1964; *Guest Faculty:* Harvey Estes, M.D., Professor of Medicine, Duke Univ. School of Medicine; S. E. Gould, M.D., Visiting Professor of Pathology, Univ. of Miami School of Medicine; Bruce Logue, M.D., Professor of Medicine, Emory Univ. School of Medicine; J. Edwin Wood, M.D., Professor of Medicine, Univ. of Virginia Medical School.

Hypertension and Its Complications, February 10–14, 1964; (In collaboration with the American College of Physicians); *Guest Faculty:* Edward D. Freis, M.D., Senior Medical Investigator, Veterans Administration Hospital, Washington, D. C.; John Eager Howard, M.D., Professor of Medicine, Johns Hopkins Univ. School of Medicine; Floyd R. Skelton, M.D., Professor of Pathology, Univ. of Buffalo School of Medicine; Cheves M. Smythe, M.D., Dean, Medical College of South Carolina; Elbert P. Tuttle, Jr., M.D., Director, Georgia Heart Association Laboratory for Cardiovascular Research, Emory Univ. School of Medicine.

Obstetric Problems in Private Practice, February 18–20, 1964; *Guest Faculty:* Charles E. Flowers, M.D., Professor of Obstetrics and Gynecology, Univ. of North Carolina School of Medicine.

Most courses are accredited by the American Academy of General Practice. Registration is limited to a small group for close participant-faculty communication. Application may be made by contacting Dr. Claude-Starr Wright, Director, Department of Continuing Education, Medical College of Georgia, Augusta, Ga.

AMA Occupational Health Congress

"America's Best Resource—the Healthy Worker," will be the theme of the 23rd National Congress on Occupational Health, in San Francisco, September 25–26. The two day meeting at the Jack Tar Hotel is sponsored by the American Medical Association's Council on Occupational Health.

The conference theme will be developed by AMA president, Edward R. Annis, M.D., Miami, Fla., in opening session remarks. The theme will be further expanded through four symposia. They are:

—Occupational health problems faced by the family physician.
—Educational resources for the practicing physician.
—Restoration to gainful employment.
—Relationship of personnel department to the medical department.

Other conference subjects include: Manipulation and Postural Balance in Low-Back Pain; Industrial Absence and the Personal Physician; Legal Responsibility of the Physician to the Nurse in Small Industry; Medical Programs for Small Plants; Community Health Resources for Small Plant Programs.

The presentation of the Annual Physician's Award of the President's Committee on Employment of the Handicapped will be made during the Congress.

The AMA meeting will be immediately followed by the two-day Seventh Annual Western Industrial Health Conference.

For additional information write: Council on Occupational Health, American Medical Association, 535 North Dearborn, Chicago 10, Illinois.

National Congress on Medical Quackery

The Second National Congress on Medical Quackery will be held October 25–26 in Washington, D.C., (Sheraton–Park Hotel). The Congress will be sponsored jointly by the American Medical Association and the Food and Drug Administration. The First National Congress on Medical Quackery was held in October, 1961, with the same sponsors.

Objectives of the Second National Congress will be to bring together again all major American groups concerned with efforts to safeguard the public against useless cures, mechanical gadgets, food fads and other quack devices and worthless treatment, said the FDA and the AMA in a joint announcement.

Extending the work of the First National Congress, the meeting next fall will seek to determine why the public is vulnerable to quackery and to determine what is needed in health education to help the public protect themselves against health charlatans.

The first of the three half-day sessions will encompass progress reports from organizations concerned with quackery. The second session will center on preventive aspects, particularly seeking the answer to the question of why people are such ready targets for quacks. The final half-day will center on the responsibilities of the communications media in protecting the public.

American Heart Association

Six clinical sessions of primary interest to the practicing physician will be held concurrently with regular scientific sessions and programs covering a broad range of cardiovascular research at the 36th Annual Scientific Sessions of the American Heart Association on October 25–27 at the Biltmore Hotel, Los Angeles. Each clinical session will include the presentation of original clinical investigative work as well as panels, symposia, and lectures.

Registration forms, which include applications for hotel accommodations, are obtainable from the American Heart Association, 44 East 23rd Street, New York 10, N. Y.

Midwest Allergy Forum

The Annual meeting of the Midwest Allergy Forum will be held at The Sheraton–Cleveland Hotel, Public Square, Cleveland, Ohio, October 12 and 13. The one and one-half days of scientific sessions will include panels on chronic pulmonary problems, cutaneous diseases, repository methods of therapy, and many other problems of clinical allergy. For further information write to I. M. Hinnant, M.D., General Chairman, 10465 Carnegie Avenue, Cleveland 6, Ohio.

Course in Laryngology and Bronchoesophagology

The Department of Otolaryngology, University of Illinois College of Medicine, will conduct a postgraduate course in Laryngology and Bronchoesophagology from September 16 through 28, under the direction of Paul H. Holinger, M.D.

Registration will be limited to fifteen physicians who will receive instruction by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Ill.

American College of Surgeons

The largest and most widely instructive meeting of surgeons in the world, the annual Clinical Congress of the American College of Surgeons, will be held during the College's semicentennial year in San Francisco, October 28 through November 1. More than 11,000 Fellows of the College and guests from all over the world will gather to discuss surgical developments of benefit to thousands of patients.

Every phase of surgery will be presented during the five-day program, through 258 research reports, ten postgraduate courses, 42 panels in general and specialty fields, 21 cine clinics, 57 medical films, 12 operative telecasts, and 329 exhibits.

Dr. Loyal Davis, Chicago, president of the College, will preside at 50th anniversary ceremonies on the opening morning. Major addresses during the week include: the Scudder Oration on Trauma, by Dr. Edwin F. Cave, Harvard Medical School; the Baxter Lecture in the field of parenteral therapy by Dr. Frederic Crosby Bartter, National Heart Institute; the Martin Memorial Lecture, which commemorates Dr. Franklin H. Martin, the College founder, by General Lauris Norstad, retired NATO commander; and on the evening of Oct. 31 the incoming presidential address by Dr. J. Englebert Dunphy, professor and chairman, department of surgery, University of Oregon Medical School. On this evening also approximately 1,050 initiates will become Fellows, of the College, having fulfilled rigid requirements for Fellowship, and Honorary Fellowships will be awarded. On the same afternoon the Distinguished Service Award winner will be named.

The College was founded in 1913 by 450 surgeons of Canada and the United States to elevate standards of surgery. Membership in this voluntary association now totals 25,500 in 79 countries. Dr. James T. Priestley, Rochester, Minn., is chairman of the board of regents of the College, and Dr. John Paul North, Chicago, is the director.

Fifth National Cancer Conference

The Fifth National Cancer Conference, sponsored by the American Cancer Society, Inc. and the National Cancer Institute, will be held September 17, 18, and 19 at the Bellevue–Stratford Hotel in Philadelphia, Pa. For further information write: Coordinator, Fifth National Cancer Conference, American Cancer Society, Inc., 521 West 57th Street, New York 19, N. Y.

American Cancer Society

The 1963 Scientific Session of the American Cancer Society will be held at the Biltmore Hotel in New York City on October 21–22. This symposium on "Unusual Forms and Aspects of Cancer in Man," sponsored by the ACS, the National Cancer Institute, and the New York Academy of Sciences, is open to all members of the medical and dental professions and students.

Topics for the sessions include: The Natural History of Untreated Cancer, Cancer at the Extreme Ages of Life, Occult Carcinoma, Radiation Induced Cancer, Cancer and Pregnancy, and Multiple Primary Cancers.

For further information, write: Director of Professional Education, American Cancer Society, 521 West 57th Street, New York 19, N. Y.

Mount Sinai Hospital Clinical Sessions

Three mornings of scientific sessions on 1963 Clinical Advances and Review will be presented by the Mount Sinai Hospital staff on Wednesday, Oct. 30, from 8:30 a.m. until 1 p.m., on Thursday, Oct. 31, from 9 a.m. to 1 p.m., and on Wednesday, Nov. 6, from 9 a.m. to 1 p.m. The course will include subjects of current general interest in obstetrics and gynecology, radiology, pediatrics, surgery, internal medicine, dermatology, and orthopedics. The program is acceptable for 12 accredited hours by AAGP. Registration fee is $25.00. For further particulars, write: Registrar, Mt. Sinai Hospital, 948 N. 12th St., Milwaukee.

Marquette Postgraduate Course

Marquette University School of Medicine in cooperation with The Milwaukee Children's Hospital will have a course in "Fluid and Electrolyte Therapy" on Sept. 26, Oct. 3, 10 and 17, 1963, in the Amphitheater of Milwaukee Children's Hospital, 1700 West Wisconsin Avenue, Milwaukee. There will be four Thursday evenings from 7 to 9:30 p.m. Directors of the course are: Gerald A. Kerrigan, M.D., associate professor of pediatrics; and Edward J. Lennon, M.D., assistant professor of medicine and director of clinical research. Reservations would be made with: Joseph W. Rastetter, M.D., Director, Postgraduate Medical Education Programs, 8700 West Wisconsin Avenue, Milwaukee, Wis. 53226.

Interstate Postgraduate Medical Association

The 48th annual Scientific Assembly of Interstate Postgraduate Medical Association, to be held at the Palmer House, Chicago, October 21–24, offers 19 and 3/4 hours of varied teaching (and A.A.G.P. Category II credit) for a registration fee of $10. The program is especially suited to the needs of generalists, as all lectures, panels and clinics are closely related to medical problems familiar to the physician who does not devote his time to a single specialty. Panels on "Neck, Shoulder And Arm Pain," "Fractures And Dislocations in Children" and "The Pros and Cons in the Use of Anticoagulants" are important parts of the three and one-half day program.

Interstate is not a "membership organization," but offers an annual teaching program for practitioners interested in a varied review of new developments in the major branches of medicine. The 1963 Assembly program offers educational exposure to more than 50 prominent medical educators, as teachers.

Those interested in full details of the program are urged to write for a brochure, by addressing a postal to N. A. Hill, M.D., Secretary, Interstate Postgraduate Medical Association, Box 1109, Madison Wisconsin, 53701.

Fall Cancer Scrimmage at Wisconsin

The ninth annual Fall Cancer Scrimmage for physicians from Wisconsin and other midwest states will be held at the University of Wisconsin at Madison Saturday, Oct. 12. Guest speaker will be Dr. Albert Seagaloff, director of research at the Alton Ochsner Medical Foundation of New Orleans. His topic will be "Various Hormones for Various Cancers."

Reports on cancer research will be presented by the Division of Clinical Oncology of the UW Medical Center and other medical faculty members. The Wisconsin Division, American Cancer Society is cosponsor of the conference. A luncheon and the Wisconsin-Purdue football game are on the afternoon program.

Dr. R. J. Samp is the program chairman and inquiries may be directed to him at University Hospitals, Madison, Wis. 53706.

American Association of Medical Assistants

A symposium on mental health, an address by the president of the American Medical Association and a discussion on electronics in the medical office will

highlight the seventh annual convention of the American Association of Medical Assistants Oct. 9–13 in Miami Beach. More than 500 physicians' aides are expected to attend the meeting, according to Miss Alice Budny, Milwaukee, Wis., AAMA president. Headquarters will be the Eden Roc Hotel.

A panel review of mental health problems frequently seen in the doctor's office will be featured on the Saturday, October 12, program. That same day, AMA President Edward R. Annis, M.D., Miami, will speak on "The Fatigue of Support." Also scheduled for Saturday is a workshop session devoted to discussions of state and county membership publications and the AAMA certification and educational programs.

The American Association of Medical Assistants is a confederation of 35 constituent state chapters. Its 11,000 members are physicians' office aides who are working under the supervision of a doctor of medicine. State and local chapters must have physician advisory committees and the approval of the local medical society.

Chicago Medical School

To meet the growing need for further training and experience in the areas of psychiatric diagnosis and treatment for general practitioners and physicians other than psychiatric specialists, basic and advanced courses will be offered by the Department of Psychiatry and Neurology of The Chicago Medical School.

The aim of the postgraduate program is to increase the skills of the physician in the diagnosis and treatment of his general patient case load and in the management of the psychiatric problems which require limited goal therapy.

Courses will be offered on Wednesdays beginning in October, 1963. There is a limited enrollment, and advance registration is required.

Address communications to: H. H. Garner, M.D., Professor and Chairman, Department of Psychiatry and Neurology, The Chicago Medical School at Mount Sinai Hospital, 2755 West 15th Street, Chicago 8, Ill.

Postgraduate Courses in Iowa

The following postgraduate courses will be offered by the College of Medicine at the State University of Iowa during the months of September and October: Sept. 14–15: Radiology; Sept. 18–19; Pediatrics; Oct. 11: Diagnostic Techniques in Office and Surgical Urology; and Oct. 18: Arthritis and Rheumatism.

For full particulars, write: John A. Gius, M.D., Director, Postgraduate Medical Studies, State University of Iowa, Iowa City.

Wisconsin Nurses Association

"Target: Progress Through Learning" is the theme of the annual convention of the Wisconsin Nurses Association, to be held October 2 through 4 at the Hotel Schroeder, Milwaukee. A total attendance of 1,000 registered professional nurses is expected.

This year for the first time "Clinical Sessions" of broad interest will replace programs of sections of the association. Each clinical session will be presented twice on Thursday, October 3; the subjects will include "Nursing in Today's Technical World," "The Professional Nurse in a Helping Relationship," and "An Approach to Analyzing Nursing Problems."

All registered professional nurses in the state, whether members or not, are invited to attend the convention.

Betty M. Callow, director of the occupational health division of Employers Mutuals of Wausau, is president of the Wisconsin Nurses Association. Nicholas Hasenstab, a supervisor at Veterans Administration Hospital, Tomah, and Mrs. Elizabeth Regan, assistant professor of nursing, University of Wisconsin Extension Division, Milwaukee, are candidates for president-elect.

Ianthe C. Harris, R.N., New York, assistant executive director of the American Nurses Association, will represent the national organization at the convention and will take part in discussions of ANA's Proposed Goal III, which if adopted would provide that within 20 to 30 years, the baccalaureate program would become the basic educational foundation for professional nursing.

Wisconsin nurses, proud of Judith Peterson, a student at Methodist Hospital School of Nursing, Madison, and president of the National Student Nurses Association, have invited her to speak at the annual WNA luncheon, social highlight of the convention, on Wednesday.

Warren Guthrie, Ph.D., chairman of the department of speech, Western Reserve University, Cleveland, Ohio, will speak at the Wednesday afternoon general session on "But Is Anybody Listening?" Helen C. Hanson, R.N., associate professor, St. Olaf College, Northfield, Minnesota, will speak on "What Society Expects of the Nurse of the Future" at a general session on Thursday morning; her talk will provide the background for a panel discussion on ANA's Proposed Goal III.

The Conference Group on Psychiatric Nursing Practice will meet Wednesday evening to hear Ruth M. Szopinski, ACSW, psychiatric social worker at Milwaukee County Mental Health Center, South Division, speak on "Remotivation." Also on Wednesday night George Collentine, M.D., director of the St. Mary's Hospital Burn Center, Milwaukee, will speak on "Treatment and Care of the Burn Patient" at a joint program meeting of the Head Nurses

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Branch and the Operating Room Nurses Conference Group.

Continuing nursing care for patients after they leave hospitals will be the subject of the Friday morning general session, and Mrs. Marthasue Houston, R.N., who has been working on this special project at University Hospital, Columbus, Ohio, will preface the panel discussion with a talk on "Looking to the Future in Continuing Care."

On the panel will be Louise C. Smith, R.N., professor of nursing, University of Wisconsin School of Nursing, Madison, moderator; Elizabeth Doelker, R.N., Manitowoc County public health nurse; Mrs. Mildred Henning, R.N., Superintendent of Eau Claire County Home, and Mrs. Elizabeth Patterson, R.N., supervisor of the out-patient department, Mt. Sinai Hospital, Milwaukee.

Results of elections for WNA officers, directors, and for section officers will be announced at the closing business session of the House of Delegates on Friday afternoon. Besides Mr. Hasentab and Mrs. Regan, the candidates for WNA officers and directors are:

Second vice-president: Mrs. Elizabeth Krzewinski, director of nursing, Milwaukee County Mental Health Center-South Division, Milwaukee; Mrs. Kathleen L. Morton, staff nurse for the Waukesha County Health Department.

Treasurer: Mrs. Johanna Anderson, supervisor, Waukesha Memorial Hospital, and Adelia Vangen, senior nurse at University Hospitals, Madison.

Members of the Board of Directors (3 to be elected): Constance Friday, Stevens Point; Mrs. Edith Geske, Milwaukee; Mrs. Ann L. Hansen, Manitowoc; Edward B. Kruk, Tomah; Ruby Nagler, Madison; Mrs. Verna A. Nelson, Superior; Ann Carolyn Smith, Madison; Mrs. Janet Theno, Ashland.

Committee on Nominations (two to be elected): Alyce F. Barlow, Oshkosh; Mrs. Ann Carlson, Janesville; Mrs. Frances L. Hendrickson, Eau Claire; Richard W. Link, Superior.

Milwaukee Medical Conference

"Operation: Medical Update" will be the theme of the third annual Milwaukee Medical Conference to be held at Milwaukee County Hospital on Nov. 20 and 21. The conference is open to all physicians. Dr. Edwin H. Ellison is chairman of the Conference Planning Committee. The program has been approved for 12 hours, Category I credit by the AAGP. Registration fee is $5.00. There is no registration fee for interns, residents, and medical students.

For full particulars, write: The Medical Society of Milwaukee County, 756 N. Milwaukee Street, Milwaukee.

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1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

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DEADLINE: Copy must be received by the 15th of the month preceding month of issue. Send copy to: Wisconsin Medical Journal, Box 1109, Madison 1, Wis.; or phone ALpine 6–3101.

PHYSICIANS' EXCHANGE: This section is limited to physicians and others desiring physician placement, sale of medical practice or equipment of a physician, sale or lease of medical buildings, etc. Advertisements from individual members of the State Medical Society of Wisconsin are accepted without charge. Widows of deceased member physicians are allowed to advertise without charge. The rates quoted above apply to ads placed by clinics and others. There is no additional charge for ads with Dept. numbers. For these ads, address replies to: Dept. ___, % Wisconsin Medical Journal, Box 1109, Madison 1, Wis. Advertisers using Dept. numbers forbid the disclosure of their identity. All inquiries are forwarded to them immediately.

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PHYSICIANS' EXCHANGE

WANTED: INTERNISTS—GENERAL PRACTITIONERS in college health service at the University of Wisconsin. Excellent opportunity. Possibilities of academic appointment. Salary $11,000–$15,000, dependent on qualifications. Contact Peter L. Eichman, M.D., Director of Student Health, University of Wisconsin, 1300 University Avenue, Madison 6, Wisconsin. g6tfn

WANTED: OPHTHALMOLOGIST to rent or buy an office building. Write for full particulars to: E. A. Miller, M.D., 80 N. Main St., Clintonville, Wis. g8tfn

FOR SALE: GENERAL PRACTICE in industrial city of approximately 50,000 in central Wisconsin. Fully staffed, fully manned 275-bed open staff hospital. Good recreational facilities. Should gross $35,000 the first year. Contact Dept. 64 in care of the Journal. m8tfn

FOR SALE: Established EENT practice, over 40 years in the heart of Milwaukee. Excellent referrals; will introduce; retiring. Contact Dept. 24 care of the Journal. m12tfn

OFFICE SPACE for two or three physicians, OB or two surgeons. To rent or to sell. Pharmacy in same building. Contact Dept. 33 in care of the Journal. m3tfn

WANTED: GENERAL PRACTITIONER as associate. Immediately available opportunity to practice in well established group of two. Replacement for sudden loss of partner. Eventual partnership. 126 E. Main Street, Madison. AL 6–3171. m9tfn

WANTED: PSYCHIATRIST. Medical Director, Community Mental Health Center. Supervision and consultation in interdisciplinary setting involving diagnosis, treatment, community services. Board certification or eligibility with training and/or experience in child psychiatry. Full or part-time; full-time range $18,000 to $25,000; part-time salary commensurate. Starting salary dependent upon training and experience. Contact: James Jensen, M.D., President, Board of Directors, Sheboygan County Guidance Center, Court House, Sheboygan, Wis. 8

WANTED: GENERAL PRACTITIONER as a replacement in town of 1,275 in southern Wisconsin. Gross receipts $42,000 in 1961, over $24,000 first 6 months 1962. Unopposed, good schools, churches, roads, fishing. Nearby accredited 200 bed hospital. Leaving for residency. Contact: D. L. Minter, M.D., Clinton, Wis. m9tfn

WANTED: PHYSICIAN with military service fulfilled to associate with a general surgeon also in general practice in northeastern Wisconsin in a city of 75,000. Excellent salary leading to early partnership. This is an A-1 financial opportunity. An early interview is appreciated. Contact Dept. 43 in care of the Journal. m4tfn

OPPORTUNITY!

This community is seeking two general practitioners to locate in a spacious, fully equipped $80,000 clinic to be completed in the city this fall. Brillion has a population of 1,800 and three major industries with a combined employment of 800, and a total annual payroll of $4,000,000. The needs of industry alone will easily support two doctors.

Brillion is located in one of the richest agricultural areas in Wisconsin, and the living conditions, working conditions, and income potential are excellent. Housing is available. Write or phone Oliver C. Wardell, c/o The Brillion Iron Works, Inc., Brillion, Wisconsin.

FOR SALE: Two level home and office on bank of river; 45-acre estate near town of 6,000, 70 miles north of Madison. Hospital, good schools, several churches. Man with surgical training desirable. Purchase may be made by land contract. Might consider a locum tenens with potential permanent arrangement. A highly flexible opportunity for the right person. Contact Dept. 23 in care of the Journal. m12tfn

WANTED: INTERNIST, Board certified, to join two established surgeons. Excellent office facilities. Opposite 300-bed hospital—200-bed added expansion in progress. Town of 15,000. Central Wisconsin. Guaranteed salary. Percentage and partnership early prospects. Contact Paul F. Doege Medical Center, 512 St. Joseph Ave., Marshfield, Wis. m3tfm

WANTED: GENERAL PRACTITIONER for association with two-man group located near Madison. Excellent hospital and recreational facilities. Salary open to start with partnership opportunity at end of one year. New building with excellent equipment and personnel. Contact Dept. 52 in care of the Journal. m4tfn

GENERAL PRACTICE FOR SALE. Physician desiring own x-ray equipment may purchase radiographic, fluoroscopic and therapy equipment. Seven-room office on main corner in southern Wisconsin city of 35,000 occupied for over 40 years. Wish to retire. Reasonable price. Contact Dept. 19 in care of the Journal. m11tfn

PARTNER IN GENERAL PRACTICE WANTED in Green Lake county, town of 5,000. Fifty-bed private hospital. Five grade schools and one high school. No predominant nationalities. Various churches. Main occupations are leather, fur and metal. Contact Dept. 20 in care of the Journal. m11tfn

URGENTLY NEEDED: Associate going for residency—another man urgently needed. Twelve miles east of Fond du Lac, Catholic rural area. Start at $1,300 or more monthly. No investment. Available June. Contact Jos. F. Miller, M.D., Mt. Calvary, Wis. m4tfn

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WANTED: INTERNIST, Board certified or eligible for association with young internist in southeastern Wisconsin city of 90,000. Contact Dept. 980 in care of the Journal. m4tfn

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FOR SALE: IN WISCONSIN. General practice, well established, same location 40 years, fully equipped 7-room office. Will take any reasonable offer and finance as you wish. Poor health forces retirement. Contact Dept. 912 in care of the Journal. m4tfn

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WANTED: PHYSICIAN to share a clinic which is now occupied by an M.D. and a D.D.S., located in a prosperous southeastern Wisconsin industrial and farming community where the need for another physician is very great. Contact Dept. 827 in care of the Journal. 4tfn

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FOR SALE: PEDIATRICS PRACTICE in suburb of large Wisconsin city; will introduce; buyer assume two-year lease; open hospital staff; physician leaving Sept. 1, 1962, for academic post. Contact Dept. 985 in care of the Journal. m5tfn

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WANTED: GENERAL PRACTITIONER to become associated with small group in central Wisconsin, preferably one who has had some practical experience, and has a special interest in obstetrics; also willing to only assist in surgery. Contact Dept. 969 in care of the Journal. m2tfn

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OFFICE SPACE in medical clinic, 2218 North Third Street, Milwaukee, Wis.; Co. 4–2800. m3tfn

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WANTED: GENERAL PRACTITIONER to replace physician who left for residency training. Fully equipped office available immediately. Town of 2,100 offers good hospital, skiing, hunting, golf, fishing and many other recreational advantages along the Chippewa River near its junction with the Mississippi. Financial remuneration should be excellent from the start. Contact Dept. 7 in care of the Journal. m9tfn

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WANTED: GENERAL PRACTITIONER for associate with two other general practitioners in community of 2,400 with trade area of 7,000 in Green county. No investment required. Excellent clinical and diagnostic facilities. 200 bed hospital 15 miles. Good educational facilities. Convenient communications to recreational areas. Contact M. W. Stuessy, M.D., Brodhead. m3tfn

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GENERAL PRACTICE available immediately in Milwaukee, Wis. (southeast side). Established 35 years, busy active practice, excellent location, beautiful ground floor clinic building, air-conditioned. Contact Dept. 41 in care of the Journal. m4tfn

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WANTED: GENERAL PRACTITIONER. Must be graduate of class A medical school, preferably with two-year internship from class A teaching hospital. Midwest industrial city of 46,000. Open staffed, fully equipped, 250-bed hospital. Equal partnership if satisfactory within two years. Excellent recreational facilities. Have well established general practice. Contact Dept. 57 in care of the Journal. m5tfn

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WANTED: OB-GYN physician and a general practitioner with some general surgical training to associate with another physician. Beautiful, large, new, well-equipped office. Parking lot. Air-conditioned. Starting salary $1,000. Partnership. City 10,000; drawing area 20,000. North Central Wisconsin. Contract Dept. 46 in care of the Journal. m4tfn

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WANTED: GENERAL SURGEON, well qualified, to join two man clinic group in community of 40,000. Excellent facilities and limitless opportunity. State qualifications and availability when contacting Dept. 61 in care of the Journal. m7tfn

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FOR SALE: American Sterilizer Company autoclave, interior dimensions 8" x 8" x 15½", model 548A. Val V. Quandt, M.D., 57 South Main Street, Hartford, Wis. m7tfn

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GOOD LOCATION AVAILABLE for general practitioner. Nothing to buy. Will assist and refer all general practice cases. Contact C. A. Sholtes, M.D., Richland Center, Wis., Midway 7–2592 or 7–2544. m9tfn

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FOR SALE: GENERAL PRACTICE, well trained and active, in new fully equipped clinic building. Present physician leaving for residency. Personnel well trained and efficient. Rural village 38 miles northeast of Madison. New school, swimming pool, good housing available. Subsidy can be arranged through village. Contact Joseph G. Brown, M. D., Cambria, Wisconsin. m6tfn

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FOR SALE: GENERAL PRACTICE in Chippewa Falls, Wis.; well established, same location for 17 years, fully equipped 5½-room office. Will take any reasonable offer and finance as you wish. Office help available. Practice available because of recent death of William F. Janc, M.D. Contact Mrs. William F. Janc, 300 Macomher Street, Chippewa Falls, Wis. m7tfn

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MEDICAL SUITE: Thiensville–Mequon Medical Center Building, Thiensville, Wisconsin. Two doctors' offices, four examining rooms, lead lined x-ray room, laboratory, general office and waiting room. Heating and air conditioning furnished by owner. Available Nov. 1, 1963. Phone Chestnut 2–1080 or Chestnut 2–2344. E. C. Neidner, 231 South Main Street, Thiensville, Wisconsin. 5tfn

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WANTED: GENERAL PRACTITIONER as associate in a four-man group with adequate clinical facilities. Offer open for two or three year locum tenens or for permanent association in the group. Town of 4,000, well-equipped 80-bed hospital, in west central Wisconsin. Contact Dept. 10 in care of the Journal. m9tfn

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EENT SPECIALIST NEEDED for Eau Claire and vicinity, population 60,000. Could take over 20-year practice of deceased physician. Very advantageous opportunity. Contact Mrs. S. B. Russell, 114½ Grand Avenue West, Eau Claire, Wis. m3tfn

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WANTED: USED EQUIPMENT of a physician. Young physician establishing private practice in Madison interested. Contact Dept. 34 in care of the Journal. m3tfn

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WANTED: GENERAL PRACTITIONER or internist to take over immediately a large established practice on new northwest side of Milwaukee. Practice and office could accommodate two doctors if desired. New medical clinic building with all modern features includes private parking area, business office, large private office, four examining rooms, x-ray and laboratory facilities. Contact Dept. 56 in care of the Journal. m5tfn

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GROUP OF THREE desires general practitioner as associate. New clinic building with adequate facilities, in town of 5,500. Recent graduate preferable. Contact Plymouth Clinic, Plymouth, Wis. m4tfn

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LOCATION WANTED: Either general practice or radiology or combination. Board eligible in radiology and experienced GP. Will serve several small hospitals in radiology, or will purchase retiring physician's equipment. Contact Dept. 51 in care of the Journal. m4tfn

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WANTED: GENERAL PRACTITIONER, immediate full partnership in active practice now grossing $50,000, all advantages of dual practice with vacation periods and free weekends. No investment required. Full hospital privileges. Contact Dept. 53 in care of the Journal. m4tfn

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WANTED: A two man partnership would like a general practitioner interested in internal medicine or an internal medicine man to become associated. Location is in north central Wisconsin. New hospital facilities are available as well as a large extensively equipped office. Contact Dept. 59 in care of the Journal. m7tfn

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FOR SALE: RETIRED PHYSICIAN has solid walnut examining table, Hamilton instrument cabinet, stool and refuse container in excellent condition; Miller Electro scalpel outfit with diagnostic kit; new magnifying lamp and many other items of current use. Cheap. George S. Metcalf, M.D., 1213 Columbus Circle, Janesville, Wis. m8

ALLERGIST WANTED to share offices with dermatologist. Located in thriving area, south central Wisconsin. Unusual opportunity. Applicant must be board certified or qualified and intending to become certified. Reply, with details of personal and professional qualities and qualifications, to Dept. 5 in care of the Journal. m8tfn

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UNUSUAL OPPORTUNITY in unopposed solo practice in Wyoming, Iowa (Jones County), due to sudden death of only physician. Short distances to three hospitals. Air-conditioned house-office combination available if desired. Prosperous rural area. Collections 95%. Address inquiries to Mrs. C. R. Smith, Wyoming, Iowa. Phone HUbbard 8-3230. p8-9

OUTSTANDING OPPORTUNITY for a young physician who is willing to work. Good schools, good 100-bed hospital. Good fishing and hunting. Retiring. Contact Dept. 32 in care of the Journal. m7-9

FOR RENT: OFFICE SPACE, 1200 sq. ft., for medical offices in modern, air-conditioned building at 16 East Gorham Street, Madison. Available for immediate occupancy. Will accommodate one or two physicians, preferably internists. Off-street parking. Contact Robin Allin, M.D., 1313 Fish Hatchery Road, Madison, Wis., phone ALpine 6-5521; or residence CEdar 3-2082. m8tfn

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WANTED: PEDIATRICIAN for two-man department in 13-man multi-specialty group located in southern Wisconsin city of 37,000. Salary first two years, then share in profit. Excellent retirement and vacation policy. Contact Dept. 58 in care of the Journal. 6-11

WANTED: GENERAL PRACTITIONER or man with specialty who will do general practice and associate with one or two other men in well established practice. Fox River Valley. Immediate opening. Community of 50,000. Salary two years, then partnership. Contact Dept. 38 in care of the Journal. m4-5

WANTED: OPHTHALMOLOGIST for newly organized group in the Fox River Valley of Wisconsin. Community of over 50,000. Excellent living conditions, noted recreational area and above average opportunity. Salary two years then partnership. Contact Dept. 45 in care of the Journal. 4tfn

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WANTED: GENERAL PRACTITIONER to join general practitioner in well established practice in southeastern Wisconsin. Town of 8,000. Class A accredited hospital. Salary or partnership if mutually agreeable. Contact Dept. 39 in care of the Journal. m3-5

URGENTLY NEEDED: General Practitioner to become associated with small clinic group in Milwaukee, Wis., preferably one who has had practical experience and a special interest in obstetrics or industrial surgery. First year, salary; then profit percentage leading to partnership. Contact Dept. 48 in care of the Journal. m4tfn

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GRADUATED MEDICAL ASSISTANT, of Career Academy, Milwaukee, seeks employment in physician's office. Qualified to do EKG, BMR, microhematocrits, glucose, injections, complete blood counts, urinalysis, and chest x-rays. 19 years old, unmarried. Reasonable salary expected. Carolyn Daniels, 521 Newhall St., Green Bay, Wis. p8

WANTED: GENERAL PRACTITIONER to replace retired physician in established three-man group. Must be interested in general medicine, obstetrics, and willing to assist in surgery. Fully equipped medical suite including x-ray and laboratory in town of 50,000 in Fox River Valley of Wisconsin. Unusual opportunity with eventual partnership. Contact Dept. 36 in care of the Journal. m3tfn

---

PHYSICIAN WANTED: General practitioner in northeastern Wisconsin wants part time help. Can use one man or combination to cover practice for week, month, or up to a year. Money no object for right man. No OB or surgery unless desired. Living facilities and car available. Contact Dept. 29 in care of the Journal. m1tfn

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FOR SALE: Genophthalmic chair, Genophthalmic refractor, Claison projector, eye glass display cabinet, treatment table, records from eye, ear, nose and throat practice—42 years. Price very reasonable. J. J. Sharpe, M.D., 150 E. First St., Fond du Lac; telephone 291 and 349. m3tfn

---

WANTED: PHYSICIAN to associate with two established general practitioners in southeastern Wisconsin industrial, agricultural community of 6,000. Prefer one who has had special surgical or obstetrical training and willing to do general practice along with surgery or obstetrics. Contact Dept. 31 in care of the Journal. m1-3tfn

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HELP! Two-man practice with only one man! General practitioner. Small town. Salary first year; partnership later. T. S. Westcott, M.D., 115 West Chestnut St., Pardeeville, Wis. m3tfn

---

GENERAL PRACTITIONERS for psychiatric treatment center. Present salary range $10,896–$14,196 with possibility of legislative increase July 1, 1963. Excellent comprehensive fringe benefit program, 40-hour week and limited furnished housing for single physicians or small families available at nominal cost. Please contact W. J. Urben, M.D., Superintendent, Mendota State Hospital, 301 Troy Drive, Madison, Wis. g4tfn

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GENERAL PRACTITIONER desires associate or partner. Liberal terms. No down payment. Two open staff hospitals. Plenty of work and plenty of recreational opportunities. A. B. Kores, M.D., Beaver Dam, Wis. m3tfn

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PLAN FOR PSYCHIATRIC residency for July, 1964? NIMH General Practitioner program: $12,000 yearly, partially tax free. Three-year approved, balanced didactic and clinical training. In Michigan's Vacationland. Dr. Curtis W. Page, Training Director, Traverse City State Hospital, Traverse City, Michigan. 6-10

OFFICE FOR RENT: Wonderful location for a physician wanting to change or physician starting practice. Five-room office, heated, low rental (or possibly no rent at all to start; landlord anxious to help area obtain physician), newly remodeled, location in concentrated area with drawing population of 10,000. Has own shopping center. Two and one-half miles from downtown Milwaukee. Would be only physician in area which wants doctor very badly to take over practice of deceased physician who was there 26 years. Tremendous potential with cooperation of area businessmen and churches guaranteed. Contact Allen Pearson, Pearson Drugs, 501 N. 29th Street, Milwaukee, Wis.; or phone DIvision 4-5050. 6-8

WANTED: MEDICAL DIRECTOR for institution for the retarded. Specialty in pediatrics or internal medicine required. Staff of five physicians plus consultants in all specialties. Salary $18,672 to $21,672 depending on qualifications. Write: Mr. John M. Garstecki, Superintendent, Southern Colony and Training School, Union Grove, Wisconsin. g8tfn

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ASSOCIATE WANTED in general practice. $18,000 guaranteed clear per year. Should earn $30,000 clear after two years. Contact Jos. F. Miller, M.D., Mt. Calvary, Wis. m7tfn

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WELL ESTABLISHED 6 man group in Iowa town of 6,300 needs board eligible or certified internist immediately. Community building a new hospital. Salary first year, then percentage of net. Salary open. Contact Dept. 63 in care of the Journal. 7-8

FOR SALE: Air-conditioned first floor office building, 1800 sq. ft., supplemental rental income from three dental offices upstairs. Owner in practice 13 years before leaving, had large, active practice. In city of Mayville, Wis., near Horicon marsh recreational area, state's largest cities for cultural, shopping activities. Open staff hospitals nearby. Contact Mr. Earl Anderson, 607 Seitz Ave., Mayville, Wis. m7tfn

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FOR SALE: Equipment of retiring physician, including National cautery; two Hamilton steeltone examination room suites—one buff, one white; Birtcher crystal bandmaster diathermy, with surgical attachments; accessories; various small instruments and treatment room supplies. Contact Mr. Harvey Schellpfeffer, 44 N. Main St., Mayville, Wis. m7tfn

INDEX TO ADVERTISERS

Ames Company, Inc. ---- 65

Barr X-ray Co. ---- 26
Borden's ---- 46
Burroughs Wellcome & Co., Inc. ---- 16

Chatham Pharmaceuticals, Inc. ---- 25
Ciba ---- 6, 7
Coca Cola Company, The ---- 58

Davies, Rose & Company, Ltd. ---- 29

Endo Laboratories ---- 22

Haug Drug Company ---- 20
Hotel Schroeder ---- 13
House of Bidwell, Inc. ---- 26
Hurley X-ray Company ---- 46

Keeley Institute, The ---- 13

Lederle Laboratories ---- 28
Lilly and Company, Eli ---- Front cover, 18

Medical Protective Company, The ---- 30
Milwaukee Sanitarium Foundation ---- 46

Parke, Davis & Company ---- 2, 3
Physicians' Exchange ---- 61, 62, 63
Professional Business Service ---- 4
Progressive Products ---- 59

Rennebohm's ---- 46
Robins Co., Inc., A. H. ---- 47, 48, 49, 60
Roche Laboratories ---- Back cover
Rogers Memorial Hospital ---- 30
Rorer, Inc., William H. ---- 24
Rowley & Schlimgen ---- 35

Sacred Heart Sanitarium ---- 64
St. Croixdale Sanitarium ---- 4
St. Mary's Hill Hospital ---- 57
Sanborn Company ---- 15
Saunders Company, W. B. ---- 9
Searle & Co., G. D. ---- 19
Shorewood Sanitarium ---- 26
Smith Kline & French Laboratories ---- 52

Time Insurance Company ---- 26

Wallace Laboratories ---- 10, 11, 13, 14, 17, 50, 51
Winthrop Laboratories ---- 8, 21, 44
Wisconsin Physicians Service ---- 12

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William H. McCreary, Jr., M. D.
Mario M. Oliveira, M. D.

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

CONTENTS

Vol. 62, No. 9 SEPTEMBER 1963

SCIENTIFIC ARTICLES

Clinical Use of Radioisotopes for Organ Scanning, by R. C. Meade, M.D. and D. A. Franklin, M.D., Milwaukee ---------- 365

The Perilimbal Suction Cup: A New Method for Early Diagnosis of Glaucoma, by L. L. Garner, M.D., F.A.C.S., Milwaukee ----- 371

Levels of Consciousness in Acute Head Injuries, by B. S. Salibi, M.D., Marshfield --- 375

Clinicopathologic Conference, by R. L. Kascht, M.D., Waukesha ---------- 383

SPECIAL ARTICLES

Postherpetic Neuralgia (abstract) -------- 370

Comments on Treatment: Treatment of Poisoning Due to Cyanide, by James L. Way, Ph.D., Milwaukee ---------- 378

Smallpox Vaccination in Hospitals -------- 379

EDITORIALS

President's Page: We Can Learn from Others, by W. J. Egan, M.D., Milwaukee ------- 390

Down the Drain ---------- 393

Spare the Young ---------- 394

REGULAR FEATURES

Letters ---------- 7

News of Wisconsin Physicians ---------- 27

Obituaries ---------- 37

Medical Meetings ---------- 43

Facts About Wisconsin Physicians Service --- 54

Bookshelf ---------- 55

Physicians' Exchange ---------- 65

Index to Advertisers ---------- 68

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Journal
Established 1903
Annual Subscription-------$6.00
Single Copy---------- 1.00
Previous Years'---------- 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Deorborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 303 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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LETTERS

TO KEEP THE RECORD STRAIGHT

To DOCTOR GOLDSTEIN:

We enjoyed very much your fine editorial on the chiropractic problem in the July issue of the Wisconsin Medical Journal. We could not agree with you more.

However, there is one inaccuracy we would like to call to your attention. Louisiana was not mentioned along with Massachusetts and Alabama as the only states without chiropractic licensure. The Louisiana State Medical Society is extremely proud of the fight it has led for many, many years to keep our state from granting legal recognition to the cult of chiropractic.

The State Medical Society of Wisconsin is to be congratulated for its outstanding work in combatting quackery. We have had wonderful reports on the success of the Conference on Health Fads and Fallacies sponsored by your society and hope that the Conference on Medical Quackery which will be sponsored by our society in March will be equally successful.

George H. Hauser, M. D.
President
Louisiana State Medical Society

MOBILE UNIT SURVEY

To RICHARD MINTON, M.D.
Racine County Medical Society

I should like to thank you for your thoughtfulness in expressing to us your personal appreciation and that of the Racine County Medical Society for the work of our mobile unit technicians in your county survey. Since their work is too often considered as expected and routine by the public, I will forward copies of your letter to each one of them. It is rare indeed when their efforts are acknowledged and appreciated, and such knowledge will be extremely rewarding.

The mobile unit survey in Racine county, as measured by the degree of public turnout, was exceptionally successful. Using the population estimates for the area east of I 94 which you received from Dr. Albert Edwards, Racine City Health Commissioner, we calculate that 31 per cent of all persons 20 years of age and over were screened by x-rays and for hypertension. Since in other parts of the state we seldom exceed 21 per cent for this age group, the turnout in Racine was 50 per cent greater. For the group over 40 years of age (the most important group for chronic disease case-finding) our state turnout averages about 19½ per cent. In the Racine county area under consideration it was an almost incredible 51 per cent—over two and one-half times as great! And of this latter group of 20,110 persons who were screened by x-ray and for hypertension, three-fourths were also screened for diabetes.

The outstanding excellence of public participation in the Racine mobile unit screening program appears even greater when measured with population data from our own Division of Vital Statistics. We do not have population data using I 94 as a boundary, but do have very accurate 1962 estimates for urban and suburban Racine City combined. I assume that this is probably close in geographic context to the county segment east of I 94. Using such urban-suburban Racine population as a measuring base, the screening participation of the age group over 20 (62,950 persons) increases from 31 per cent to 34 per cent; that of the age group over 40 (33,510 persons) rises from an incredible 51 per cent to a more remarkable and more incredible 60 per cent.

In either event, this exceptionally high degree of public participation in the mobile unit survey in your area can only be credited to the role played by the Racine County Medical Society. The only variable factor among all the mobile unit surveys carried on in Wisconsin since 1945 and the present Racine survey is the strong leadership and real active work of your physician members. For the past 20 years, we have always had our mobile units and our technicians have always worked long hours, hard and willingly; local health departments have always organized and conducted the surveys, and many volunteer groups have served in them. But in this particular instance, unlike others in which the county medical societies merely voted "approval" for a survey, the physicians of the Racine County Medical Society not only "approved" but enthusiastically and voluntarily assumed the leadership and responsibility to strengthen this valuable health service to their people. They gave their valuable time for continuous participation in the planning, organization and conduct of the survey and cooperated extremely well with the public health services and all other interested groups. I know that the public will never be able to fully appreciate the extent of the great personal sacrifice made by the Society's physicians in their behalf.

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing.

Address all correspondence to:
The Editor
Wisconsin Medical Journal
Box 1109
Madison, Wisconsin 53701

The enlightened interest of the physicians in the Racine County Medical Society, and their unselfish service and valuable contributions in behalf of the health of their people, as evidenced in this survey, has never been closely approached, by any other organized medical group within Wisconsin, and possibly not within this country. I am not, of course, referring to emergency epidemic or disaster situations where the services of the medical profession have always been freely forthcoming, or to "immunization campaigns", but to this more recent type of public health and medical problem involving early detection and secondary prevention of the major chronic diseases—now our nation's greatest causes of disability and death.

Our survey work in Racine county is not nearly over. The important follow-up phase yet remains. This involves those persons who are referred to their physicians for diagnostic examination because of screening abnormalities. Strangely enough not all these people go to their physicians when it is recommended that they do so. Additional individual effort will be required from the doctors and health department personnel to persuade the members of this group (about one-third of those referred) that it is in their interest to seek the recommended medical examination. And the public must recognize that the best of screening tests are about 70 per cent accurate; that when, after undergoing recommended examination some are declared to be well by their doctors, they should be thankful rather than resentful. A medical check-up is more important than a car check-up!

I know that the medical society, health department and public of Racine will wish to receive the final follow-up results. Sufficient reports from which to compile this data, usually come to the State Board of Health about six to nine months after a survey. As soon as possible we will release the tabulated results to you.

From what has been said thus far it is obvious that the Racine County Mobile Unit Survey has demonstrated an important, desirable fact—that private medicine as organized today and official public health agencies can work closely together as co-leaders in fighting the newer health problems which face our people. It is my hope that when all the necessary data is available, the survey description and results will be published as a joint venture in an appropriate medical journal. This should serve as a stimulus toward similar close and harmonious *active* participation by other medical societies and health departments in our combat with the major health problem of our nation—not the contagious diseases, but the chronic illnesses.

I appreciate fully the valuable contributions of the many other groups which were involved in making the Racine survey an outstanding success—labor and management, fraternal and religious organizations, radio, press, television, and many others, particularly the Woman's Auxiliary of your Society. Nevertheless I know that the leadership, support and proven interest of the physicians of the Racine County Medical Society served as a great source of encouragement to them and stimulated and intensified their efforts.

Kindly extend the thanks of the State Board of Health to the physicians of your Society. It is interesting that we feel grateful to each other, not for any actions which serve our own interests, but in our mutual concern to preserve the health of the public.

MILTON FEIG, M. D., *Director*
Section on Preventable Diseases
State Board of Health

MEDICAL WRITING FELLOWSHIPS

To WMJ:

The W. B. Saunders Company is pleased to announce that Dr. Herman Kalckar, Professor of Biochemistry at Harvard Medical School and Dr. Paul Beeson, Ensign Professor of Medicine at Yale University School of Medicine are the award winners of Saunders 75th Anniversary Writing Fellowship.

As you may recall from our original announcement last summer, this grant was to provide for a year's leave of absence for an eminent investigator to think about, write about, and bring to print the results of his research. No strings were attached regarding any rights of publication accruing to Saunders.

Because of the large and enthusiastic response by distinguished medical scientists, and because of the number of outstanding applications received by the Selection Committee, the committee recommended to Saunders that two equal grants of $15,000 be made available. This is instead of the single grant previously announced. The Saunders Company accepted the recommendation.

The work of the two grantees represents two of the most significant bases upon which modern medicine stands—cellular chemistry and clinical observation.

We hope our writing award contributes, in at least this instance, to easing the problem of investigators finding the time to communicate the results of their research to others.

GEORGE W. BRAUCKMAN
Advertising Director
W. B. Saunders Company

INTERPRETATION DIFFERS

To WMJ:

It was interesting to note that the interpretation by some reporters on the recent smoking survey of Wisconsin physicians by the Wisconsin Division of the American Cancer Society in cooperation with

the Wisconsin State Medical Society was different than the figures released from the actual survey.

The survey quizzed 652 Wisconsin physicians and discovered that only 332 of them had once been smokers. Of the actual 332 smokers, 84 had quit which figures out to approximately one-fourth. Some of the papers erroneously reported that only one-eighth of the physicians had quit because they compared the 84 to the total 652, all of whom were not smokers to begin with. I'm sure you will agree that one-fourth of any group quitting smoking is much more impressive than one-eighth and that the physicians deserve the credit due them in view of the fact that there has been a gradual increase in the overall cigarette consumption by the public.

ROBERT H. MILLER
Assistant Executive Director
Wisconsin Division
American Cancer Society

CYTOLOGY SPECIAL ISSUE

To WMJ:

Your May 1963 issue on the *Cytologic Revolution* is one of the best pieces of work written on the subject of cytology and you people should be congratulated on it.

SANDRA L. RUITER
Executive Secretary
Cancer Cytology Foundation of America

MARQUETTE SPECIAL ISSUE

To WMJ:

The golden-covered July issue of the WISCONSIN MEDICAL JOURNAL is very attractive. I want to thank the editors for all of the trouble and effort that went into preparing this Anniversary issue. I am sure that the JOURNAL will be read with great interest by many graduates of the Marquette University School of Medicine who are located in Wisconsin.

JOHN S. HIRSCHBOECK, M. D.
Dean, Marquette University School of Medicine

PHYSICIANS SEEKING LOCATIONS IN WISCONSIN

Physicians seeking locations in Wisconsin, physicians seeking relocation in Wisconsin, or physicians seeking associates may contact the Placement Service of the State Medical Society of Wisconsin, Box 1109, Madison 1, or phone ALpine 6–3101. A file listing communities and/or physicians seeking physicians or associates is maintained. There is no charge for this service of the Society.

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DQ-2

NEWS OF WISCONSIN PHYSICIANS

Begins Madison Residency

Dr. Richard L. Wesenberg has recently begun residency in radiology at Wisconsin General Hospital, Madison, after completing a year of internship at the Hartford Hospital, Hartford, Conn. The residency is a three-year program to train specialists in the field of x-ray diagnosis and therapy. Doctor Wesenberg's home is Kewaskum.

Dr. Marks Moves to Olympia, Wash.

Dr. John Marks, Black River Falls, has accepted a position with the Washington State Public Health Department. Doctor Marks, a former member of the Krohn Clinic and Hospital staff, recently completed a course in public health at the University of Minnesota.

Dr. Iverson Joins Simenstad Clinic, Osceola

Dr. Dale A. Iverson, of Cooperstown, N. D. and a graduate of Baylor Medical School, Houston, Texas, has begun duties as a general practitioner with Simenstad Clinic, Osceola. His internship was completed at the Chas. T. Miller Hospital in St. Paul, Minn.

Muirdale Picks Medical Chief

Dr. William W. Stead, clinical director of Muirdale Sanatorium, Milwaukee, for the last three years, has been appointed medical director to succeed Dr. A. V. Cadden who retired. Doctor Stead came to the sanatorium in 1960 from the University of Florida. He is chairman of the pulmonary disease board of the American Board of Internal Medicine.

Dr. John U. Peters Joins Gavin Clinic

Dr. John U. Peters, a native of Nicktown, Pa., has joined the staff of the Gavin Clinic, Fond du Lac. He served his internship at St. Joseph's Hospital in Flint, Mich., served two years in the air force and served a year of general practice residency at Lafayette Charity Hospital on the Louisiana State University campus. Doctor Peters received his M. D. degree from Georgetown University Medical School, Washington, D. C., in 1959.

Orthopedic Surgeon Opens Practice in Neenah

Dr. William F. Kennedy has established an independent practice, in orthopedic surgery, in Neenah. Doctor Kennedy is a 1956 graduate of the Marquette University School of Medicine and interned at Columbia Hospital, Milwaukee, 1956–1957. A member of the Milwaukee County Medical Society, he was appointed assistant instructor in orthopedic surgery at Marquette in 1960, a position which he still retains.

Dr. Haskins Reelected St. Joseph's Chief

Dr. Paul Haskins was reelected chief-of-staff at the annual medical staff dinner meeting, St. Joseph Hospital, River Falls. *Dr. Frederick Klaas* and *Dr. Ferdinand Grassl* retained the vice-president and the secretary-treasurer posts respectively. Other members of the medical staff include *Dr. Roland Hammer, Dr. Phillip Gutzler, Dr. Eugene Jonas* and *Dr. Donald Dohnalek.*

Dr. Gerndt Joins Manitowoc Clinic

Dr. Harold L. Gerndt, formerly of Muscatine, Ia., has started the practice of general surgery with the Manitowoc Clinic. Doctor Gerndt received his M. D. degree from the State University of Iowa in 1958. A year of internship was spent at King County Hospital, Seattle, Wash., then four years of residency in general surgery and thoracic surgery at the Veterans Administration Hospital, Des Moines, Ia.

Dr. Davis Joins Madison General

Dr. John B. Davis has joined the staff of Madison General Hospital, Madison, as assistant radiologist. Doctor Davis received his M. D. degree from the University of Wisconsin Medical School and interned at Madison General. From 1955 to 1960, he was in private practice in Markesan, and for the past three years has been at Columbia Hospital on a radiology residency.

Testimonial Dinner for Dr. John Karsten

Dr. John Karsten, who has practiced medicine for 40 years in Horicon, was honored at a testimonial dinner and reception sponsored by the Horicon Rotary Club and the Horicon American Legion Post. *Dr. John Hirschboeck*, dean of the school of medicine, Marquette University, served as guest speaker.

Fellowship Grant at Mayo Clinic

Dr. R. L. Hansen, who has been associated with the Colby Clinic, Colby, for the last 10 years, has been granted a three-year fellowship at the Mayo Clinic for study in pediatrics. Doctor Hansen is a graduate of the University of Wisconsin Medical School and served his internship at St. Joseph Hospital, Marshfield, before coming to Colby.

Dr. Jerry Salan Establishes Practice

Dr. Jerry Salan has established his practice in Waupaca, locating in the office of his father, *Dr. Sam Salan.* During the last two years, Doctor Salan has been a resident at Wilmington General Hospital Wilmington, Del. He received his M. D. degree from Northwestern University in 1960 and spent his internship at Passavant Hospital, Chicago.

Physicians whose names appear in italic are members of the State Medical Society.

Marshfield Clinic for Amputees Established

The Marshfield Clinic has established an amputee clinic which is held once a month. A team consisting of *Dr. R. A. Pyka*, orthopedic surgeon, Jan Grey, physiotherapist, and a prosthetist representing the artificial limb manufacturers conduct the clinic. They are interested in assisting amputees to improve and extend the use of their artificial limbs.

Dr. Johnson Opens Madison Office

Dr. Elmer E. Johnson has opened his office for the practice of ophthalmology in Madison. He is a graduate of the University of Wisconsin Medical School and served his internship at Madison General Hospital. A three-year residency in disease and ophthalmologic surgery was completed at the University of Wisconsin and the Veterans Administration Hospital, Madison.

Dr. Randall Joins Office of Dr. Leicht

Dr. John H. Randall has joined the Green Bay medical office of *Dr. Thomas Leicht*. Doctor Randall came to Green Bay from Madison where he served his internship and a three-year residency in internal medicine and hematology at the University of Wisconsin Hospital. He is a graduate of the State University of Iowa Medical School, Iowa City.

Beloit Clinic Has New Physician

Dr. David K. Criswell, who received his M. D. degree at Northwestern University, has joined the staff of Beloit Clinic. Doctor Criswell did his internship and residency in obstetrics and gynecology at Passavant Memorial Hospital, Chicago.

Completes MEDICO Mission in South America

Dr. Paul K. Odland, Janesville orthopedic surgeon has returned from a month of service for MEDICO in Colombia, S. A. Teaching, operating, and consulting were done in Bogota, Cartagena, and Barranquilla. Climax of the trip was the proposal by a Colombian orthopedist that they form a Medico service of their own, taking turns going into the jungle villages and volunteering their talents to the people there. This alone made the service worthwhile, Doctor Odland contended.

Dr. Joel Brende on St. Croix Clinic Staff

Dr. Joel O. Brende has joined the staff of the St. Croix Falls Clinic. He is a graduate of the University of Minnesota Medical School and interned at Bethesda Hospital, St. Paul, Minn.

Back From Japan

Dr. D. Murray Angevine has returned to Madison after a year in Japan, where he served with the Atomic Bomb Casualty Commission in Hiroshima.

Dr. Algiers Resumes Practice

Dr. James L. Algiers, who completed a three-year postgraduate course in internal medicine at Milwaukee County General Hospital, recently reopened his office in Hartford. His practice is limited to internal medicine.

Dr. Russell Receives Mayo Fellowship

Dr. Thomas J. Russell has been awarded a three-year fellowship at the Mayo Clinic for the study of dermatology. He previously had been serving a rotating internship at Minneapolis General Hospital since graduation from Marquette University School of Medicine in 1962.

New Physician for Rice Lake

Dr. Peter Lameka recently began practice in Rice Lake, associated with Drs. Maser, Cotts, and Kristensen. Doctor Lameka received his M. D. degree from Marquette University School of Medicine in 1960. He subsequently entered the army medical corps and served with the third armored division in Germany.

Dr. Raymond New Associate of Dr. Grab

Dr. Lou A. Raymond is the new associate to *Dr. John A. Grab*, Sun Prairie. Doctor Raymond recently completed his internship at Madison General Hospital.

Dr. Peterson Opens Office

Dr. Jack Peterson, former member of the Waupun Clinic, has opened a new practice with *Dr. Paul Carrol* in Waukesha in obstetrics and gynecology. Doctor Peterson recently completed a year of residence at the Medical Center, Hermann Hospital, Houston, Tex.

New Clinic Director

Dr. Dick Vodegel, staff psychiatrist at Winnebago State Hospital, has been appointed medical director of the Washington-Ozaukee Guidance Center. He replaces *Dr. Jack Geist* who will have full-time private practice in Milwaukee. Doctor Vodegel was born in Indonesia and raised in Holland where he received his M. D. His residency in pediatrics and internal medicine was served at Bethesda Hospital, St. Louis, Mo. Psychiatric residency was at Hastings State Hospital, Neb., and University Hospitals, Madison.

Radiologist Added to Marshfield Clinic

Dr. Marvin L. Hinke has joined the staff of the Marshfield Clinic in the capacity of radiologist. For the past year he has been an instructor in radiology at the University of Wisconsin Medical School.

Dr. Mastalir Leaves Burlington

Dr. L. O. Mastalir, a Burlington physician for 31 years, has sold his partnership in the Burlington Medical Center and moved to Shorewood, a suburb of Milwaukee. He also resigned as the Burlington pub-

lic health officer. Doctor Mastalir sold his practice to *Drs. D. J. Baker, Robert Wheaton* and *Paul Gander*, Burlington.

Dr. Bramschreiber Enters Practice

Dr. Jerome Bramschreiber has become associated with the Lynn Clinic, Green Bay, in internal medicine. During the last year he was a National Institutes of Health fellow in gastroenterology. He is a graduate of the University of Cincinnati College of Medicine.

Joins Monroe Clinic

Dr. James H. Weeks is a new pediatrician at The Monroe Clinic. Doctor Weeks previously was in Hudson, N. Y., where he was on the staff of Rip Van Winkle Clinic. He received his M. D. from George Washington University School of Medicine, Washington, D. C.

Dr. Hearn Joins West Bend Clinic

Dr. Richard F. Hearn of Milwaukee has become associated with the General Clinic of West Bend. He received his degree in medicine from Marquette University in 1961; he interned at Misericordia Hospital, Milwaukee.

Dr. Gehring Joins Green Bay Doctors

Dr. John V. Gehring is now associated with *Drs. Charles A. Wunsch* and *James F. Caffrey*, Green Bay, whose practice is limited to psychiatry. Doctor Gehring received his M. D. degree at Marquette University, interning at Misericordia Hospital, Milwaukee. He took residency training at the Mental Health Institute, Cherokee, Ia.

Heads 1964 Heart Fund

Dr. Martin Janssen, Adams, has been named to head the 1964 Heart Fund campaign in Adams and Friendship, it was announced by *Dr. Charles W. Crumpton*, Madison, president of the Wisconsin Heart Association.

Heads Health Planning Group

Dr. John E. Dettmann Green Bay, has been named co-chairman of the Health Planning Council for Brown County as medical society representative. Doctor Dettmann and John Torinus, De Pere, will head a 25-member citizens committee to carry out the recommendations of the recently completed study on the care of the aged and chronically ill in Brown County.

Dr. Gagan Joins Dr. Garman

Dr. R. J. Gagan, Albuquerque, N. M., has joined *Dr. John Garman* in his Waterloo clinic. Doctor Gagan is a graduate of Marquette University and for the past several years has been a Navy medical officer at Sandia Base Hospital, Albuquerque, in pediatrics and obstetrics.

Discuss "Medicare"

"Medicare—Medical Care of the Aged" was discussed recently at the Janesville Rotary Club by a panel consisting of *Dr. Marvin Roesler*, Robert Burmeister and Ron Richardson, Janesville.

Japanese Women Doctors Visit Three Lakes

Two distinguished women doctors, Dr. Takuko Yonetsu, pediatrician and head of her own hospital in Tokyo, and Dr. Takako Sekiguchi, obstetrician, visited recently at a resort at Three Lakes. They are presently on a tour of major U. S. hospitals. Comment was made of their amazement at "the wilderness, the abundance of water and the purity of the air," with none of which, they said, is Japan so well endowed.

Dr. Rundle Heads Guidance Center

Dr. Frank Rundle, Madison, is the new psychiatric director of the Grant County Guidance Center, replacing Dr. Richard Lee, Dubuque, Ia. Doctor Runddle received his degree from the University of Wisconsin Medical School and has been teaching at the medical school.

Resumes Palmyra Practice

Dr. R. G. Handeyside has resumed his full-time practice in Palmyra after completing a two-year course in advanced surgery at the Milwaukee Hospital and Veterans Administration Hospital, Wood.

Dr. Whereatt to Manitowoc

Dr. Richard R. Whereatt has joined *Dr. N. A. Bonner* in the Doctor's Building, Manitowoc. Doctor Whereatt specializes in general and thoracic surgery. He received his M. D. from Marquette University in 1954 and interned at St. Joseph Hospital, Milwaukee. He also has served as a captain in the U. S. Medical Corps and as resident physician at Illinois Central Hospital, Chicago. He practiced at Hammond, Ind., before coming to Manitowoc.

Dr. Reifenrath Joins Mary Hill Clinic

Dr. William Reifenrath, Milwaukee, has joined the staff at Mary Hill Clinic, Menomonee Falls. Doctor Reifenrath graduated from Marquette medical school, interned at Misericordia Hospital, and did his residency at Milwaukee County Hospital. He was certified by the American Board of Surgery in 1962 and practices in partnership with his father, *Dr. I. B. Reifenrath*, in Milwaukee.

Dr. Blink Joins Medical Group

Dr. Donald V. Blink, Oshkosh, has become associated with the East Grand Medical Group, Wisconsin Rapids, in the practice of general medicine. Doctor Blink has just completed two years of active duty with the Navy Medical Corps. He received his M. D. from the University of Wisconsin and interned at the Minneapolis General Hospital.

AMA Delegates Named

Dr. John M. Bell, Marinette, has been named a delegate and *Dr. James C. Fox* of LaCrosse an alternate delegate to the American Medical Association. Doctor Bell succeeds *Dr. L. O. Simenstad*, Osceola, as one of Wisconsin's four delegates to the AMA. Doctor Simenstad recently was elected to the AMA board of trustees.

Dr. Karzel Joins Medical Center

Dr. Ronald P. Karzel, has joined the Janesville Medical Center in the capacity of surgeon. For the past four years he has been a resident surgeon at University Hospitals, Madison.

Dr. Gersch Joins Clinic Staff

Dr. George Gersch has joined the staff of the West Salem Clinic. He is a 1961 graduate of Marquette medical school and served his internship at St. Mary's Hospital at Grand Rapids, Mich., in obstetrics and gynecology.

Dr. Heywood is Life Director

Dr. Robert M. Heywood was elected to a life term as director of the Marshfield Clinic. Doctor Heywood, a specialist in internal medicine and allergy, has been associated with the clinic for the past three years. He continues also as a director of the Marshfield Clinic Foundation for Medical Research and Education, a position he has held for the past two years.

Dr. Gilbert Joins Dr. Stoklos

Dr. Michael Stoklos, Brookfield, announced that *Dr. Francis Gilbert*, Waukesha, has become associated with him. Doctor Stoklos will devote most of his time to internal medicine, while Doctor Gilbert will handle obstetrics. Doctor Gilbert is a fellow of the American College of Obstetrics and Gynecology and received his M. D. from the Boston University School of Medicine. His internship was at DePaul Hospital, Norfolk, Va. and residency was at U. S. Naval Hospital, Portsmouth, Va. He has been a staff medical officer in obstetrics and gynecology at the U. S. Naval Hospital, Jacksonville, Fla., and in private practice since 1960.

Dr. Backer Locates in Wausau

Dr. Gordon L. Backer, who has been a resident in ophthalmology at the Mayo Foundation in Rochester, Minn., has left that city and will be located in Wausau.

Dr. Finley Moves to Milwaukee

Dr. Marcus L. Finley has completed his residency in plastic surgery at the Mayo Foundation in Rochester, Minn., and will now be located in Milwaukee.

Dr. Martin New Surgeon at Wabasha

Dr. David Martin, Omaha, Neb., has joined the Community Clinic, Wabasha, as general surgeon, succeeding Dr. Johannes Leonhardt who tendered his resignation recently. Doctor Martin attended Yale University medical school and received an added degree in surgery at Tufts Medical College, Boston. For the past year, he has been associated with the Veterans Administration Hospital, Omaha. He served on the faculty of Tufts and also the University of Nebraska. He has written several papers on organ transplants and arterial sclerosis.

Dr. End Opens New Office

Dr. Edgar End has announced the opening of his new office at 7610 West Center Street, Milwaukee.

Dr. Crow Named to State Board of Health

James F. Crow, Ph. D., medical genetics professor and acting dean of the University of Wisconsin Medical School, Madison, has been nominated to the State Board of Health. His nomination was one of four Gov. John W. Reynolds announced; all four require State Senate confirmation. Doctor Crow fills the unexpired term of Dr. John S. Hollingsworth, Sheboygan. Also nominated for the board was *Dr. William B. Gallagher*, LaCrosse. The Board of Health post pays $10 a day and expenses.

Surgeon Joins River Falls Clinic

Dr. Walter Orlow has joined the staff of the River Falls Medical Clinic. He received his degree in medicine from Ohio State University and served his internship at Miami Valley Hospital, Dayton. After a tour of duty in the U. S. Air Force, he returned to surgical training at St. Luke's Hospital, Cleveland.

Dr. A. C. Edwards Honored

The staff of St. Clare Hospital, Baraboo, has honored *Dr. A. C. Edwards* at a dinner. Doctor Edwards recently completed his 50th year in the practice of medicine. Receiving his medical degree in 1913, Doctor Edwards was one of the first staff members at St. Mary's Ringling Hospital when it opened in 1922.

Dr. Starr Joins Clinic Staff

Dr. Clifford H. Starr, Milwaukee County Hospital, has joined the staff of the Garrison-Handy Clinic, Wisconsin Rapids. He will be associated with *Drs. Rogers E. Garrison, George H. Handy, Andrew W. Hulme*, and *Andrew M. Lucas* in general surgery. Doctor Starr received his M. D. from Marquette and interned at Misericordia Hospital, Milwaukee. He later was associated with *Dr. Dowe Cupery*, Markesan, and *Dr. Lorne Campbell*, Clear Lake, before returning to Milwaukee County for a pathology residency; also, he was an attending physician at the Milwaukee County Emergency Hospital and the Milwaukee County Hospital for Mental Diseases.

Dr. Strebe to Oconto Falls

Dr. Kenneth L. Strebe, Marshfield, has opened his practice in Oconto Falls. Doctor Strebe received his M. D. degree from Marquette University. He interned at St. Joseph's Hospital in Marshfield.

Dr. R. G. Love to Shullsburg

Dr. D. J. Garland, Shullsburg, has terminated his practice which has been taken over by *Dr. Robert G. Love*, Cuba City. Doctor Garland has practiced in Shullsburg since August, 1949, and has now moved his family to Tucson, Ariz. Doctor Love is a graduate of the University of Maryland Medical School and spent his internship and residency in Massachusetts. He served in the U. S. Army and since has been associated with the Cuba City Medical Center since March, 1962.

Accepts Post at Willowbrook

Dr. David N. Goldstein, Kenosha, has accepted an appointment as superintendent of Willowbrook, tuberculosis sanitorium. He also continues as medical director at Willowbrook, a position he has held the past three years.

Obstetric Institute

A day-long institute was held this summer at St. Mary's Hospital, Wausau, to bring about 150 Wisconsin nurses and obstetricians up-to-date on current knowledge of childbirth. The Charitable, Educational and Scientific Foundation of the State Medical Society and the State Board of Health sponsored the institute in cooperation with several other medical groups. *Dr. Alex Krembs*, Milwaukee, served as chairman. Other speakers and panelists at the eight sessions were *Dr. A. H. Stahmer*, Wausau; *Drs. F. J. Hofmeister, George S. Kilkenny, John Evrard*, and *Joseph Devitt*, and Mrs. Wealthy Lawtonn, R. N., Milwaukee; *Drs. T. A. Leonard* and *William Kiekhofer*, Madison; and Dr. Vasil Truchly, Chicago.

All expenses were paid by the State Board of Health and the CES Foundation, except for $2 registration fees for those attending. The speakers donated their time. Such programs are conducted frequently on request of the CES Foundation. Doctors attending will be eligible for credit from the American Academy of General Practice.

Medical Clinic Formal Opening

The River Falls Medical Clinic, latest addition to the medical facilities in River Falls, held an open house during its formal opening in June. The staff includes *Drs. Philip Gutzler, Paul Haskins, Ferdinand Grassl, Roland Hammer*, general medicine; *Dr. Donald Dohnalek*, radiology; and Dr. Walter Orlow, surgery. Operation of the clinic is under its administrator, Edward Jenkins. He came to the clinic in 1947 as an x-ray technician, taking over the administrative duties in 1951.

Kiwanis Hears Dr. Pellicer

New methods of heart resuscitation in cases of cardiac arrest were described in a motion picture shown recently to the Kiwanis Club, New Holstein. The picture was secured through the cooperation of Dr. J. G. Pellicer, Brillion, who also offered explanations concerning the procedure.

Freeport Speaker

Dr. R. E. Oertley, Darlington, was a guest speaker at the Freeport Kiwanis Club. He discussed atomic radiation.

Dr. Shockley Certified

Dr. Benjamin F. Shockley, Milwaukee, has recently been certified by the American Board of Surgery.

Joins Jackson Clinic Staff

Dr. Louis F. Warrick, Jr., has joined the staff of the Jackson Clinic, Madison, in the department of internal medicine. A native of Madison, Doctor Warrick received his premedical training at the University of Wisconsin and George Washington University Medical School, Washington, D. C., graduating from the latter. He served his internship at Emergency Hospital, Washington, D. C., and a three-year residency in internal medicine at the Washington Hospital Center. During the last year of his specialty training he served as chief administrative resident. Upon completion of his residency in 1961, Doctor Warrick served two years in the Public Health Service as chief medical officer at the Federal Reformatory for Women at Alderson, W. Va.

Dr. H. E. Smith to Clinton

Dr. Harold E. Smith was welcomed to Clinton recently at a reception in his new office. Doctor Smith is a graduate of the University of Wisconsin Medical School and interned in Toledo, O.

Elcho Honors Dr. Dailey

Dr. Paul J. Dailey, Elcho, was honored recently at an open house at the Elcho school gymnasium in observance of his 50th year in the medical practice, most of which was spent in Elcho. He was graduated in 1913 from Marquette School of Medicine, and practiced in Elcho a short time before locating at Elcho.

Two Physicians Join Grantsburg Clinic

Drs. Erik P. Eselius and John F. Stageman have joined the Grantsburg Clinic. Doctor Eselius attended the University of Dayton and is a 1962 graduate of Marquette University School of Medicine, Milwaukee. He completed his internship at St. Mary's Hospital, Duluth, Minn., this year. Doctor Stageman, Pontiac, Mich., has recently been with the U. S. Air Force, Altus, Okla., and is a 1960 graduate of the State University of Iowa.

Instructs in Resuscitation Procedures

Dr. Larry Hanley, Whitehall, acted as instructor at three meetings held in Whitehall and attended by Boy and Explorer Scouts, members of the local police department, personnel of the county sheriff's office, the fire department, hospital staff, and the two local life guards. Films were shown, after which Doctor Hanley demonstrated mouth-to-mouth resuscitation.

In Health Posts

Dr. William T. Clark, Janesville, has been reelected president of the State Board of Health and *Dr. Edward N. Vig*, Viroqua, named as its vice-president. Doctor Clark has headed the eight-member board since February, 1960. He has served as a board member since 1943.

Named to Mental Health Campaign Post

Dr. Arthur C. Tompsett, resident radiologist at St. Nicholas Hospital, Sheboygan, has been named as chairman of the professional division in the current mental health fund-raising campaign. The drive is intended to raise $10,000 for the Sheboygan County Association for Mental Health. Doctor Tompsett is a member of the association's professional advisory committee. He joined St. Nicholas Hospital staff in 1950 following a three-year residency in radiology at St. Joseph's Hospital in Ann Arbor, Mich.

UW Creates Cancer Unit

Dr. Anthony R. Curreri, Madison, has been named director of a new division of clinical oncology in the University of Wisconsin Medical School. The division replaces the tumor clinic which Doctor Curreri headed until Dr. Raymond Brown was appointed its director last year. Doctor Brown will continue his research in the division. James F. Crow, Ph. D., acting dean of the medical school, said the new group would be engaged primarily in clinical research on cancer.

Dr. Wendt Begins 31st Year

Dr. F. A. Wendt, Johnson Creek, was honored recently in the form of a statement of tribute by the citizenry of Johnson Creek. Doctor Wendt has been a resident of Johnson Creek for 30 years and has practiced medicine there for that time.

Dr. Grace Moves to North Carolina

A Monroe physician, *Dr. Eugene V. Grace*, has left that city for North Carolina where he will have a private office in Durham and will be a part-time teacher of ophthalmology at the University of North Carolina, Chapel Hill. He received his medical degree from the University of Michigan in 1956.

Brodhead Doctor Honored

Dr. M. W. Stuessy was honored recently on the 25th anniversary of his medical practice in Brodhead. Doctor Stuessy opened his office there in 1938 following graduation from Louisville University. In 1944, he began planning a clinic which was opened in July 1951 as the Stuessy Clinic.

Joins Pember—Nuzum Clinic

Dr. Charles S. Baker specialist in internal medicine, has joined the Pember-Nuzum Clinic, Janesville. Doctor Baker, a native of Rochester, N. Y. received his B. S. and his M. D. degrees from the University of Illinois. He completed his residency in internal medicine at Hines Veterans Hospital.

Dr. Simeon Leaves Lancaster

Dr. Rudolpho Simeon, former Madison physician, who has been associated with *Dr. Elgie Houghton*, Lancaster, for several months, has terminated his association with Doctor Houghton.

Opens Practice in Eau Claire

Dr. Verne A. Sperry, Brookfield, Ill., will be associated with *Drs. Harry E. Thimke, Robert O. Bjurstrom*, and *Walter M. Kelley*, Eau Claire, in the practice of anesthesiology. Doctor Sperry took undergraduate work at Loyola University, Chicago, and is a graduate of the Stritch School of Medicine of Loyola. He completed his residency at the State University of Iowa hospitals and interned at Sacred Heart Hospital, Spokane, Wash. After internship, he served three years in the Air Force medical corps.

New Physician for Wausaukee

Dr. E. A. De Guszman has opened an office in Wausaukee. For several years, Doctor De Guszman has been on the staff of St. Michael's Hospital, Milwaukee, where he also previously had completed his internship.

Ohio Surgeon at River Falls

Dr. Walter Orlow of Ohio has joined the staff of the River Falls Medical Clinic. A native of Dayton, O., he attended DePauw University and later Ohio State where he received his M. D. degree. Doctor Orlow served his internship in Dayton and, following a tour of duty in the U. S. Air Force, returned to Cleveland where he studied surgery.

Pediatrician Added to Clinic

Marshfield Clinic has added Dr. Gerald E. Porter, a pediatrician and native of Brooklyn, to its staff. Doctor Porter earned his M. D. degree from the University of Wisconsin Medical School in 1958. After internship at the University of Michigan Hospital, Ann Arbor, he took his residency in pediatrics at the State University of Iowa.

Dr. Devine to Practice in Fond du Lac

Dr. Joseph Devine has begun his Fond du Lac medical practice with *Drs. John* and *James McCullough*. Doctor Devine received his M. D. from Mar-

quette University School of Medicine. After serving his internship at Milwaukee County Hospital, Doctor Devine served in the army as a medical captain in Korea. He recently completed a surgical residency at the Milwaukee hospital.

Appointed Professor of Surgery

Dr. Robert C. Hickey, professor of surgery in the postgraduate school, University of Texas, has been appointed professor of surgery, University of Wisconsin Medical School, Madison. Doctor Hickey has been general surgeon and associate director for research at the M. D. Anderson Hospital, University of Texas, Houston.

Member of Anticoagulant Symposium

Dr. Armand J. Quick, Milwaukee, will serve on the Faculty of the International Anticoagulant Symposium to be held in January 1964 in Miami Beach, Fla. This symposium is sponsored by the Miami Heart Institute and is composed of 40 outstanding clinicians from the U. S., Canada, and overseas.

Appointed Medical Instructor

Dr. David L. Walls has been appointed an instructor in medicine, University of Wisconsin Medical School. He will work in the dermatology teaching and research program under *Dr. Sture A. M. Johnson*. Doctor Walls, a native of Pasadena, Calif., earned his M. D. from Indiana University in 1959.

Heart Disease Research Grant

The Life Insurance Medical Research Fund has announced that a grant for $27,170 has been awarded to Dr. Henry A. Lardy, University of Wisconsin Medical School, Madison, for research in heart disease. Doctor Lardy will use the grant to study intermediary metabolism with particular reference to heart muscle.

Opens Ophthalmology Practice

Dr. James R. Ferwerda, a 1957 graduate of the University of Wisconsin Medical School, has opened his office in the Kenosha Medical Center, Kenosha. He served a one-year internship at the Philadelphia General Ho pital after graduating with honors. Doctor Ferwerda practiced for two years in Whitesburg, Ky., and then undertook a three-year residency program in diseases and surgery of the eye at Milwaukee County General Hospital.

Psychiatric Discussion

Dr. Leonard Ganser, Madison, head of the division of mental hygiene, Wisconsin State Department of Public Welfare, discussed "Psychiatric Planning for the Community" at a scientific meeting held recently in the Marshfield Clinic library. Doctor Ganser reviewed the history of mental health care facilities in Wisconsin, outlined progress made, and described plans for future advances in the field of community mental health.

Dr. Hanko Honored for 50 Years Service

Dr. John E. Hanko, Reedsburg, was honored recently on the occasion of 50 years of service in the field of medicine by a smorgasbord and program in the Reedsburg Country Club.

Five New Doctors Added to Marshfield Clinic

Five additions have been made to the Marshfield Clinic. They are: Dr. Thomas F. Nikolai, endocrinology and internal medicine; Dr. Fred Fletcher, internal medicine; Dr. Robert Richards, orthopedic surgery; Dr. James Kunkel, ophthalmology; and Dr. Guerdon J. Coombs, internal medicine.

Dr. Grinvalsky Resigns from Pathology Lab

Dr. Henry T. Grinvalsky, pathologist at St. Michael's Hospital, Stevens Point, has announced his resignation. A member of many professional organizations and author of several articles, Doctor Grinvalsky was also director of the hospital's School of Medical Technology and adviser for its student organization at Wisconsin State College, Sigma Mu Tau. Drs. Francesco Sciarrone and Angelo Milano, both of whom received their medical education at St. Louis University, St. Louis, Mo., have assumed responsibility of the laboratory at St. Michael's. Doctor Sciarrone has been in private practice for the past two years at Michigan City, Ind.; and Doctor Milano has been practicing for three years in St. Louis.

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OBITUARIES

Dr. Robert S. Irwin, Milwaukee, died February 20, 1963, at the age of 64.

Born at Lodi, Doctor Irwin was a 1927 graduate of Marquette University School of Medicine. He served his internship and residency in the specialty of urology, at Milwaukee County General Hospital. From 1928–1930, Doctor Irwin practiced with his father, Dr. George Irwin, after which he returned to Milwaukee and joined the surgical staff at Milwaukee County Hospital, and served as instructor of urology at Marquette. Upon completion of military service, Doctor Irwin returned to Milwaukee as a full-time specialist in urology.

He was a former president of the State Urological Society; past president and member of the Medical Society of Milwaukee County; a member of the American Board of Urology and American College of Surgeons. He also held membership in the North Central Section of the American Urological Association; the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Helen.

Dr. Arthur J. Knauf, Sheboygan, died the week of April 14, 1963, at the age of 78.

A native of Stevens Point, Doctor Knauf was a 1910 graduate of Northwestern University Medical School and served his internship at Milwaukee Hospital from 1910 to 1911. He located in Sheboygan and was engaged in private general practice there for over 50 years.

Doctor Knauf was a member of the State Medical Society of Wisconsin, the Sheboygan County Medical Society and the American Medical Association.

Dr. Thomas C. Proctor, Egg Harbor, died May 15, 1963, at the age of 90.

He was born in Monroe City, Mo., and graduated with the class of 1895 from the Washington University Medical School, St. Louis, Mo. He did graduate work at the Manhattan Graduate School and Hospital. Prior to coming to Sturgeon Bay in 1900, he lectured in pathology at the Kansas City University Medical College, taught at the Woman's Medical School in the same city, and acted as chemist for the K.C., F.S., and M. Railroad.

Doctor Proctor was a member of the Door County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by a daughter and two grandchildren.

Dr. John T. Klein, Milwaukee, died May 29, 1963, at the age of 73.

Doctor Klein was born in Walkerton, Ontario, and came to Milwaukee at the age of three. He graduated from Marquette University School of Medicine in 1913. He served as second lieutenant in the medical corps in World War I. In 1919, he became affiliated with the Wisconsin Eletcric Power Co., as a staff physician and surgeon. He remained there for 40 years until his retirement in January, 1960.

From 1955–1960, he was chairman of the medical board of governors of the Wisconsin Electric Power Co. In 1937 he was named a fellow of the American College of Surgeons. He was chief of staff of St. Mary's Hospital in 1948, and it was through his efforts and the backing of the Wisconsin Electric Power Co. that St. Mary's Hospital opened its burn center in 1959. Doctor Klein served as the burn center's first director. He was also a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

His wife, Mary, preceded him in death on April 15, 1963. Doctor Klein is survived by four sons and two daughters.

Doctor Alphonse M. Bodden, Milwaukee, died June 17, 1963, at the age of 93.

Doctor Bodden was born in Milwaukee and graduated from the Marquette College in 1888. He received his medical degree from the Columbia College of Physicians and Surgeons in New York City in 1896. During World War I, he was an assistant medical examiner for draftees. Doctor Bodden was a Selective Service examining physician during World War II.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. He was also a member of the Milwaukee Academy of Medicine.

Survivors include three sons and a daughter.

Dr. John B. MacLaren, a former Appleton physician and surgeon, died July 13, 1963, in Milwaukee at the age of 83.

Born in Flint, Michigan, Doctor MacLaren was a graduate of Rush Medical College in Illinois in 1915. He interned at St. Luke's Hospital in Chicago, Illinois.

Doctor MacLaren located in Appleton in 1917, where he continued his practice for 44 years. He was a member of Outagamie County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Doctor MacLaren was medical director for the Kimberly Clark Corporation from 1918 until about six months prior to his death.

Doctor MacLaren was a surgeon concerned with industrial injuries in addition to having his own practice. He devoted considerable time to assisting in projects for crippled children and rheumatic fever patients.

He was a member of the American Heart Association, the Wisconsin Heart Association, Wisconsin Welfare Council, Industrial Medical Association,

New York Academy of Sciences, and a lifetime member of the American College of Surgeons.

An avid collector of clocks, he reconstructed, designed and constructed clocks, and was a member of the National Association of Watch & Clock Collectors.

He is survived by his widow and one daughter, Mrs. Donald W. Davis, Milwaukee.

Doctor William O. Sydow, formerly of Wauwatosa, Wisconsin, died July 16, 1963, at the age of 40.

Survivors include his widow, Betty, two sons, Mark and Dan; and two daughters, Ann and Barbara.

Dr. Edward A. Waldeck, Milwaukee, a specialist in ophthalmology and otolaryngology, died July 26, 1963, at the age of 65.

A native of Milwaukee, Doctor Waldeck was a 1922 graduate of Marquette School of Medicine and interned at Milwaukee County Hospital. He did graduate work in Chicago and later studied at the University of Vienna.

Doctor Waldeck was on the medical staff of St. Joseph's Hospital, was head of the eye, ear, nose and throat department at the same hospital from 1948 to 1958. In May 1963 he was appointed to the honorary staff of St. Joseph's Hospital. He also was on the medical staff of St. Anthony's Hospital.

He was a member of the American Academy of Ophthalmology and Otolaryngology, the Milwaukee Oto-Ophthalmic Society, the Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Ruth; two sons, Edward and Charles; and a sister, Mrs. Mildred Menery.

Doctor Enoch F. Peterson, retired Wauwatosa physician, died August 12, 1963, at the age of 83.

He was graduated from the College of Physicians and Surgeons, Chicago, in 1905 and practiced in Varna, Illinois, prior to locating in Wauwatosa in 1912. Doctor Peterson was Health Commissioner of Wauwatosa for 15 years.

Doctor Peterson was a former president of the Medical Society of Milwaukee County and served on its Board of Directors. He was also a member of The State Medical Society of Wisconsin and the American Medical Association.

Survivors include his widow, Lillian; three daughters, Mrs. Jacqueline Fuller, Mrs. Ruth Singley, and Doctor Freddie Peterson, and a brother, Doctor Axel E. Peterson, Toluca, Illinois.

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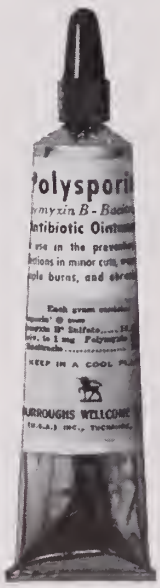

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1963 **Wisconsin**

Oct. 12: Ninth Annual Fall Cancer Scrimmage, University of Wisconsin Medical Center, Madison, sponsored by the Division of Clinical Oncology, UW, and the Wisconsin Division of the American Cancer Society.

Oct. 20–23: Annual District VI meeting of American College of Obstetricians and Gynecologists, Milwaukee.

Oct. 30–31 & Nov. 6: 1963 Clinical Advances and Review, Mount Sinai Hospital Staff, Milwaukee.

Nov. 19–20: Conference on Extension of Voluntary Health Insurance, sponsored by Wisconsin Physicians Service, at State Medical Society Headquarters, Madison.

Nov. 20–21: Third annual Milwaukee Medical Conference, at Milwaukee County Hospital, sponsored by the Medical Society of Milwaukee County.

Nov. 21: Eberbach Memorial lecture honoring Milwaukee Hospital centennial, by Dr. Carl E. Badgley, professor of orthopedic surgery, University of Michigan School of Medicine, Milwaukee.

Nov. 22: All-day symposium on Industrial Back Injuries, Mount Sinai Hospital, Milwaukee.

1964

Feb. 24–29: Wisconsin Work Week of Health, State Medical Society Headquarters, Madison.

Apr. 2–3: Annual Meeting, Wisconsin Anti-Tuberculosis Association, Coach House Motor Inn, Milwaukee.

Apr. 4: Annual Meeting, Wisconsin Thoracic Society (WATA medical section), Coach House Motor Inn, Milwaukee.

May 11–13: Scientific program of Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

1963 **Out-of-State**

Oct. 9–13: Annual Meeting, American Association of Medical Assistants, Miami Beach, Fla.

Oct. 10–13: Annual Meeting, American Society of Clinical Hypnosis, San Francisco, Calif.

Oct. 11: Course in Diagnostic Techniques in Office and Surgical Urology, College of Medicine, State University of Iowa, Iowa City.

Oct. 12–13: Annual meeting, The Mid West Allergy Forum, Sheraton-Cleveland Hotel, Public Square, Cleveland, Ohio.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, sponsored by the Council on International Affairs of the American College of Chest Physicians, Mexico City.

Oct. 13–19: XVIIth World Medical Assembly (originally scheduled in Mexico City Sept. 22–28), Commodore Hotel, New York City.

Oct. 14–18: Course in Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, International Inn, Washington D. C., American College of Chest Physicians.

Oct. 14–18: Course in Sources and Use of Toxicological Information, Institute of Industrial Medicine, New York University Medical Center, Onchiota Conference Center, Tuxedo, N.Y.

Oct. 16–19: Conference on Obstetric, Gynecologic and Neonatal Nursing, sponsored by District VI, American College of Obstetricians and Gynecologists, Chicago.

Oct. 18: Course in Arthritis and Rheumatism, College of Medicine, State University of Iowa, Iowa City.

Oct. 21–22: 1963 Scientific Session of American Cancer Society—A conference on "Unusual Forms and Aspects of Cancer in Man", Biltmore Hotel, New York City.

Oct. 21–24: Interstate Postgraduate Medical Assembly, scientific program, Chicago.

Oct. 21–25: Course in Clinical Cardiopulmonary Physiology, American College of Chest Physicians, Pick Congress Hotel, Chicago.

Oct. 22–24: Course in Fractures in General Practice, Medical College of Georgia, Augusta.

Oct. 23–25: Chiefs-of-staff Conference, University of Colorado Medical Center, Denver.

Oct. 24–26: Course in Postgraduate Gastroenterology, American College of Gastroenterology, Washington, D. C.

Oct. 25–26: Second National Congress on Medical Quackery, Sheraton–Park Hotel, Washington, D. C.

Oct. 25–27: Annual scientific sessions of the American Heart Association Biltmore Hotel, Los Angeles, Calif.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Oct. 27–Nov. 1: Annual clinical congress, American College of Surgeons, Chicago, Ill.

Oct. 28–Nov. 1: Course in Allergy and Hypersensitivity States sponsored by the American College of Physicians, at Northwestern University Medical School.

Oct. 28–Nov. 1: Annual Clinical Congress of the American College of Surgeons, San Francisco, Calif.

Oct. 30–Nov. 2: Twelfth Biennial Rocky Mountain Medical Conference, sponsored by seven Rocky Mountain state medical societies, at Las Vegas, Nev.

Nov. 2–3: National County Medical Societies Conference on Disaster Medical Care, Chicago.

Nov. 5–13: Ninth Congress of the Pan–Pacific Surgical Association, Honolulu, Hawaii.

Nov. 11–15: Course in Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Barbizon Plaza Hotel, New York City.

Nov. 13–Dec. 10: First Pan–Pacific Mobile Educational Lecture Seminar, New Zealand, Australia, Thailand, the Philippines, Hong Kong and Japan.

Nov. 15: Seventh Annual Symposium on Diabetes at the A. B. Dick Amphitheatre, Presbyterian-St. Luke's Hospital, Chicago, sponsored by the Diabetes Association of Greater Chicago.

Nov. 18–20: Scientific meeting of the Ophthalmology and Otolaryngology Section of the Southern Medical Association, New Orleans, La.

Nov. 18–21: Annual meeting of the Southern Medical Association, New Orleans, La.

Nov. 21–23: First Sectional Meeting (Midwest) of the American College of Physicians, Detroit, Mich.

Nov. 22–25: Annual convention, National Society for Crippled Children and Adults, Palmer House, Chicago.

Nov. 23: Annual meeting, American Rhinologic Society, Illinois Masonic Hospital, Chicago.

Dec. 1–4: Clinical Meeting, AMA, Portland, Ore.

Dec. 2–6: Course in Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Ambassador Hotel, Los Angeles.

1964

Jan. 5–8: First Annual Postgraduate Seminar in Anesthesiology, Miami Beach, Fla., sponsored by the University of Miami and University of Florida schools of medicine.

Jan. 9–11: International Symposium on Anticoagulant Therapy in Ischemic Heart Disease sponsored by Miami Heart Institute at Fontainebleau Hotel, Miami Beach, Fla.

Jan. 13–17: Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Hotel Fontainebleau, Miami Beach.

Feb. 2–8: Workshop in Teratology, University of Florida, Gainesville.

Feb. 7–8: Congress of the Professions, Lansing, Mich.

Feb. 17–19: Canadian-American Medical and Dental Ski Association meeting, Harbor Highlands, Harbor Springs, Mich. Sec-Treas: T. J. Trapasso, M.D., 816 Ashmun St., Sault Ste. Marie, Mich.

May 11–14: Annual scientific meeting, Aerospace Medical Association, Americana Hotel, Bal Harbour, Miami, Fla.

May 25–27: Annual meeting, American Thoracic Society, medical section of the National Tuberculosis Association, New York City.

June 15–19: Postgraduate course in Psychiatry for Internists, sponsored by the American College of Physicians, at Psychiatric Institute and the General Hospital of the University of Maryland School of Medicine.

NEW U. of W. TEACHING COURSES for 1963-1964

(in cooperation with the CES Foundation)

The University of Wisconsin Medical School and the CES Foundation of the State Medical Society are sponsoring jointly a new type of one-day teaching program, especially designed for physicians who do not devote their time to a single specialty.

Each program will consist of a "Wet Clinic" at University Hospitals, Madison, from 10:00 a.m.–12:00 noon, followed by lunch and lectures, panels, and audience discussion at the State Medical Society Headquarters. Adjournment will be at 4:00 p.m. for each meeting.

SPECIAL BUS SERVICE: Because of parking congestion around University Hospitals all registrants are requested to park their cars in the parking lot at the State Medical Society and take a chartered bus to the Hospital, leaving the State Medical Society at 9:30 a.m. Bus service from hospital to SMS at noon. **If 25 or more MDs from Milwaukee register by October 1, a special chartered bus (FREE) will be provided, leaving Milwaukee at 7:30 a.m. and returning from the State Medical Society at 4:00 p.m.**

The fee of $5.00 per conference (or $20 for the entire series of five meetings) covers lunch and bus service as noted above.

EDUCATIONAL CREDIT: For those A.A.G.P. members who attend these conferences, 4 hours of "primary credit" (old "Category I") will be provided.

WEDNESDAY, OCTOBER 9

INFECTIONS AND ANOMALIES OF THE URINARY TRACT IN CHILDREN

Faculty: U. of W.—**Drs. Charles Lobeck, James Cherry, C. R. Weatherhogg, and John B. Wear, Jr.**

Content of Program: Report on consequences of urinary infections in children, diagnosis and treatment, with special reference to the family physician.

THURSDAY, NOVEMBER. 14

FORM AND FUNCTION OF THE NERVOUS SYSTEM (including vascular diseases)

Faculty: Guest Speaker—**Adolph Sahs, M.D.,** Professor and Head of the Department of Neurology, State University of Iowa College of Medicine, Iowa City. U. of W.—**Francis M. Forster, M.D., Hartwell G. Thompson, Jr., M.D.,** and others.

Content of Program: Demonstration of what the neurological examination can reveal, case presentations on cerebrovascular syndromes, discussions on management of spontaneous subarachnoid hemorrhage, management of cerebrovascular accidents caused by cerebral hemorrhage in hypertensive vascular disease, rehabilitation of the hemiplegic patient, and effectiveness of anticoagulation therapy in patients with cerebrovascular disease.

WEDNESDAY, JANUARY 29

THE FAILING HEART

Faculty: Guest Speaker—**Walter Kirkendall, M.D.,** Professor of Medicine, State University of Iowa College of Medicine, Iowa City. U. of W.—**Drs. Charles Crumpton, George Rowe, and William Young.** Departments of Medicine and Surgery.

Content of Program: Case studies on special problems of heart failure (kidney, cor pulmonale, pediatric aspects, the pregnant woman, etc.); diuretic therapy; clinical management of congestive heart failure; cardiovascular surgery in control of congestive heart failure.

Continued on page 45

American College of Surgeons

The 1964 sectional meetings of the American College of Surgeons will be held Jan. 27–29, Baltimore, Md., Lord Baltimore Hotel; Feb. 17–19, Denver, Colo., Denver Hilton Hotel; and March 16–19, New Orleans, La., Roosevelt and Jung Hotels and auditoriums of Charity Hospital, Louisiana State University, and Tulane University. The 50th Annual Clinical Congress will be held in Chicago, Oct. 5–9, at the Conrad Hilton Hotel.

The 1965 sectional meetings will be held Jan. 25–27, Atlanta, Ga., Atlanta Biltmore Hotel; Feb. 15–17, Philadelphia, Pa., Bellevue-Stratford Hotel; and March 8–11, Seattle, Wash., Olympic Hotel and Civic Center Auditorium. The 51st Annual Clinical Congress will be held in Atlantic City, N.J., Oct. 18–22, at the Hotel Dennis.

The 1966 sectional meetings will be held Jan. 13–15, Bal Harbour, Fla., Americana Hotel; Jan. 31–Feb. 2, Houston, Texas, Sheraton Lincoln Hotel; adn March 14–17, Cleveland, O., Hotel Cleveland and Hotel Statler. The 52nd Annual Clinical Congress will be held in San Francisco, Calif., Oct. 10–14, at the Hotel Fairmont.

All inquiries regarding these meetings should be directed to Samuel J. Harbison, M.D., Secretary, 55 E. Erie St., Chicago 11, Ill.

Continued from page 44

THURSDAY, FEBRUARY 20

THE ACHING BACK

Faculty: Guest Speaker:—James Stack, M.D., Professor of Orthopedic Surgery, Northwestern University School of Medicine, Chicago. U. of W. —Drs. Jack Heiden, Herman Wirka, Henry Okagaki, Peter Golden, and Harry Bouman.

Content of Program: Review of anatomy of the back, and particular emphasis on *low back pain.* Examination, diagnosis, x-ray interpretation, and most effective methods of treatment by the family physician. Doctor Stack will discuss the intervertebral disk in relation to low back pain.

THURSDAY, MARCH 19

THYROID DISEASE

Faculty: Guest Speaker—F. Raymond Keating, M.D., Mayo Clinic, Rochester, Minn. U. of W.—Drs. E. C. Albright, E. S. Gordon, F. C. Larson, and Howard Rasmussen.

Content of Program: Discussion of new diagnostic procedures and most effective modes of therapy by the family physician. Emphasis on recent research and how new findings can be translated into improved care of patients.

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I wish to register for the one-day teaching courses checked below:

Wed., Oct. 9: PEDIATRICS: _____

Thurs., Nov. 14: NEUROLOGY: _____

Wed., Jan. 29: CARDIOLOGY: _____

Thurs., Feb. 20: ORTHOPEDICS: _____

Thurs., Mar. 19: THYROID: _____

Name: _____
(Please Print)

Address: _____

City: _____

Southern Medical Association

The 57th Annual Meeting of the Southern Medical Association will be held November 18–21 at New Orleans, La.

The EENT Section will initiate the closed T.V. sessions this year with the first attempted color production of microscopic ear surgery on Monday morning, November 18, in the Municipal Auditorium's viewing room at New Orleans.

The "Louisiana Day" session of the EENT afternoon program will follow, after a reasonable interval, Dr. Edward Annis' presentation at the President's Luncheon.

The Eye Program will include a practical review on the pathogenesis and technical management of fibrous dysplasia and timely articles concerning air rifle injuries and other traumatic injuries to the eye.

For further information write: Neil Callahan, M.D., Secretary, Section on Ophthalmology and Otolaryngology, 506 Professional Building, Portsmouth, Va.

Crippled Children and Adults

Communication in all its aspects as it affects work for the crippled will be under discussion when the National Society for Crippled Children and Adults holds its 1963 annual convention November 22–25 at the Palmer House, Chicago.

Special sessions will be directed to professional persons in the rehabilitation field, officers and board members, Easter Seal executives, parents, volunteers, business, industry and labor leaders and all others who serve crippled children and handicapped adults.

Gastroenterological Convention

The 28th Annual Convention of the American College of Gastroenterology will be held at The Shoreham, Washington, D.C., Oct. 21–23.

In addition to the several individual papers to be presented, there will be a panel discussion on amebiasis, a symposium on the esophagus, and a series of papers on gastric cooling and gastric freezing. There will again be scientific as well as commercial exhibits and the sessions will be open to all physicians without charge.

The Annual Course in postgraduate gastroenterology will again be given, Oct. 24–26. Attendance at the course will be limited to those who have registered in advance.

Copies of the program and further information may be obtained by writing to: American College of Gastroenterology, 33 West 60th Street, New York, N.Y., 10023.

Community Health Week, Oct. 20–26

The first national observance of Community Health Week is scheduled October 20–26, the American Medical Association announced.

The AMA House of Delegates adopted a resolution establishing the special observance on an annual basis last November. The objective is to focus public attention on the progress of medical science in all communities and the high quality of each community's health resources and facilities.

The House of Delegates suggested that the first Community Health Week be devoted to an examination of the broad spectrum of medical progress in the past few decades.

"With emphasis on local achievements and local responsibility, Community Health Week affords the medical society the opportunity to present the viewpoint that existing medical services are the fruits of the community's hard work in earlier years and that it is the responsibility of each citizen, working with his neighbors, to help plan now for tomorrow's needs," Dr. Edward R. Annis, Miami, Fla., AMA president, said. "Dramatizing this viewpoint, Community Health Week may serve as a potent catalyst for community action."

Annual Diabetes Symposium

The Diabetes Association of Greater Chicago will conduct its Seventh Annual Symposium on Diabetes at the A. B. Dick Amphitheatre, Presbyterian-St. Luke's Hospital, 1753 W. Congress Parkway, Chicago, Ill. on Friday, November 15, beginning at 9 a.m.

During the morning, a symposium on clinical, physiological, and biochemical aspects of hyperlipemia will be presented. In the afternoon there will be a discussion on aspects of Hurler's syndrome, diabetic neuropathy, sucrose and fructose intolerance, and a review of the use of hypoglycemic agents.

Registration is free for members of the Diabetes Association of Greater Chicago or the American Diabetes Association and for medical students and resident house staff members. The fee for nonmembers is $25.00. Inquiries may be addressed to: The Diabetes Association of Greater Chicago, 620 North Michigan Avenue, Chicago 11, Ill.

Rocky Mountain Medical Conference

A scientific program designed to provide information of everyday use to a broad spectrum of medical interests will be presented at the Twelfth Biennial Rocky Mountain Medical Conference, Oct. 30 to Nov. 2, 1963, in Las Vegas, Nev.

The conference, held in conjunction with the 59th Annual Meeting of the Nevada State Medical Association, will feature scientific papers and panel discussions by 16 nationally known physicians; plus an histologist, embryologist, and a vice-president of a national liability insurance company.

Registration at the conference is open to any Doctor of Medicine. A registration fee of $20 which includes a luncheon will be charged.

The Rocky Mountain Medical Conference is a joint enterprise of the state medical societies of

1963 MILWAUKEE MEDICAL CONFERENCE

Wednesday and Thursday—November 20 and 21

William L. Coffey Auditorium—Milwaukee County Hospital

Co-sponsored by the Milwaukee Academy of General Practice; Wisconsin Academy of General Practice, Milwaukee Academy of Medicine; State Medical Society of Wisconsin Charitable, Educational and Scientific Foundation; Sixth District, American College of Obstetricians and Gynecologists; Marquette University School of Medicine; Milwaukee County Hospital; Milwaukee Children's Hospital; Veterans Administration Hospital, Wood, Wis.; and the Milwaukee Pediatric Society.

REGISTRATION OPEN TO ALL PHYSICIANS. Registration Fee: $5.00 No fee for residents, interns, students. Acceptable for 12 hours Category I credit, American Academy of General Practice.

TENTATIVE PROGRAM

WEDNESDAY, NOVEMBER 20

12 N. Registration—Lobby, 2nd floor entrance, and stage entrance to Coffey Auditorium (continues throughout program).

P.M.
12:30 Welcome
Edwin H. Ellison, M.D., Chairman, program committee, Third Milwaukee Medical Conference
Harold E. Cook, M.D., Director, Medical Services, Milwaukee County Institutions
John S. Hirschboeck, M.D., Dean, Marquette University School of Medicine
Robert A. Frisch, M.D., President, The Medical Society of Milwaukee County

FIRST SESSION

Robert A. Frisch, M.D. presiding

12:45 Unsolved Problems in Congenital Heart Disease, Medical-Surgical Grand Round, *William W. Engstrom, M.D.*, Moderator; Introduction to the Problem, *Ramon F. Lange, M.D.*; Case Presentation, Cardiology Staff; X-Ray Findings, *John R. Amberg, M.D.*; Discussion, *William J. Gallen, M.D.*, *John H. Huston, M.D.*, and *Henry T. Bahnson, M.D.*

ETIOLOGIC FACTORS AND MANAGEMENT OF PREMATURITY

1:45 An Introduction to the Problem of Prematurity, *Richard F. Mattingly, M.D.*, Moderator

1:50 Etiologic Factors and Sequlae of Permature Labor, *Edward H. Bishop, M.D.*, Philadelphia, Pa.

2:20 Progesterone Deficiency as a Cause of Premature Labor, *Elenor Delfs, M.D.*

2:35 Current Advances in Prematurity, *Edward H. Bishop, M.D.*, Philadelphia, Pa.

3:00 Coffee break
Robert S. Haukohl, M.D., President-elect, The Medical Society of Milwaukee County, presiding

3:15 A Symposium on Problems of the Premature Infant: An Introduction to the Problem, *J. Cyril Peterson, M.D.*, Moderator

3:30 Immediate Management of the Asphyxiated Newborn with Depressed or Absent Respiration, *Jay J. Jacoby, M.D.*

3:35 Respiratory Problems in the Premature Infant Including Hyaline Membrane Disease, *Mildred Stahlman, M.D.*

4:15 Potential Role of Hyperbaric Oxygen Therapy in the Asphyxiated Newborn, *Edgar End, M.D.*

4:25 A Panel Discussion on Etiologic Factors and Management of Prematurity, *Richard F. Mattingly, M.D.*, moderator panelists, *Edward H. Bishop, M.D.*, *Elenor Delfs, M.D.*, *Edgar End, M.D.*, and *Mildred Stahlman, M.D.*

6:30 to 8:30 Reception honoring Conference participants at Stouffer's Top 'o the Marine, 111 E. Wisconsin Avenue. Open to all paid registrants and their wives of the Milwaukee Medical Conference.

THURSDAY, NOVEMBER 21

PRACTICAL APPLICATION OF NEW KNOWLEDGE TO EVERYDAY MEDICAL PROBLEMS

Joseph S. Devitt, M.D., presiding and moderating

A.M.
10:00 Diagnosis by Inspection in Infancy and Childhood, *Harry Shirkey, M.D.*, Birmingham, Ala.

10:30 Interpretation and Indications for Mammography, *John R. Amberg, M.D.*

10:50 When is Isotope Scanning of Value to the Physician?, *Robert C. Meade, M.D.*

11:10 Resuscitation in the Adult, *Derward Lepley, Jr., M.D.*

11:30 Drug Treatment in Children, *Harry Shirkey, M.D.*

12 N. Question and answer period on Doctor Shirkey's presentation

P.M.
12:10 When is Renal Dialysis of Value? *Edward J. Lennon, M.D.*

12:30 Lunch—Dutch Treat, Cafeteria, Milwaukee County Hospital

MEDICAL UPDATE, 1963

James M. Sullivan, M.D., presiding and moderating

1:30 Indications for and Techniques of Therapy for Available Cancer Chemotherapy Agents, *John D. Hurley, M.D.*

1:50 Initial Treatment of the Acute Burn, *Joseph C. Darin, M.D.*

2:10 Increase in Tuberculosis Among Senior Citizens: A Problem for One Physician and a Threat to the Next Generation, *William W. Stead, M.D.*

2:30 Office and Bedside Evaluation of Pulmonary Function, *Ross C. Kory, M.D.*

2:45 Coffee break

Continued on page 48

seven states; Colorado, Idaho, Montana, New Mexico, Nevada, Utah, and Wyoming. For further program details and conference information, write to: Thomas S. White, M.D., General Chairman; Rocky Mountain Medical Conference; 3660 Baker Lane, Reno, Nev.

American College of Physicians

More than 100 physicians will be on the scientific program of the American College of Physicians' First Sectional Meeting (Midwest), to be held November 21–23 in Detroit, Mich.

Following the general format of the College's Annual Meeting, the Sectional Meeting will consist of general clinical sessions, combined clinical investigation and basic science sessions, panel discussions and symposium.

According to Dr. Edward C. Rosenow, Jr., Philadelphia, Pa., Executive Director of the American College of Physicians, the three days will be devoted entirely to postgraduate activities. No formal social events or business meetings of the College are scheduled.

Two sessions will be held concurrently mornings and afternoons in the Sheraton-Cadillac Hotel. On each morning, medical scientists will present general clinical lectures at one session and reports on clinical investigations and basic science activities at the other.

Thursday afternoon's program will consist of symposia on upper gastrointestinal hemorrhage and pulmonary disease problems. Symposia on cardiac arrhythmias and interpretation of antibody response in disease are scheduled for Friday afternoon. Concluding sessions, on Saturday afternoon, will be panel discussions on subacute bacterial endocarditis and cerebrovascular disease.

Plans for the First Sectional Meeting (Midwest) are under the direction of Dr. Wesley W. Spink, Minneapolis, Minn., President of the American College of Physicians and Professor of Medicine at the University of Minnesota. Dr. James T. Howell, Detroit, Mich., Henry Ford Hospital, is chairman of the Local Committee on Arrangements.

Disaster Medical Care Meeting

The 14th National County Medical Societies Conference on Disaster Medical Care, sponsored by the American Medical Association's Council on National Security, will be held Nov. 2–3 at the Pick-Congress Hotel in Chicago. The meeting is designed for medical and health personnel concerned with disaster preparedness programs.

Rep. F. Edward Hebert (D., La.) the House committee member and chairman of its subcommittee which considers civil defense legislation, will speak at a luncheon session on Sunday, Nov. 3, discussing civil defense in the U.S.

The workshop meetings will be from 2–5 p.m. Saturday, Nov. 2, and cover the following topics: community health service planning, mass casualty care, hospital planning, training and utilization of allied personnel, medical education for national defense, civil defense emergency hospitals, and coordination of the medical effort with other aspects of civil defense.

Two symposiums on planning and resources are scheduled for Saturday morning's opening session. A third symposium dealing with AMA and government activities in civil defense and disaster care will be held Sunday morning.

Saturday's luncheon speaker will be Lt. Col. Richard L. Coppedge, MC, surgeon for the Special Warfare Center, Ft. Bragg, N.C. He will discuss the medical role in the special forces.

Additional information and advance registration are available from the Council on National Security, AMA, 535 North Dearborn, Chicago 10, Illinois.

AMA 17th Clinical Meeting

More than 7,000 physicians and their guests are expected to converge on Portland, Ore., for the 17th Clinical Meeting of the American Medical Association, December 1–4.

Lectures, panels, symposia and breakfast roundtables again will be presented at the Portland meeting on specially selected topics, as well as color television and medical motion pictures. More than 100 physicians will deliver lectures on the scientific program during the four-day meeting, and more than 200 scientific and industrial exhibits will be shown at the Coliseum, many of which will be based on new scientific research.

A symposium on "Genes, Chromosomes, and Immune Mechanisms" will be held on Monday, Dec. 2. The same subject will be covered in a guest lecture on Tuesday morning by Rupert E. Billingham, Ph.D., of the Wistar Institute, Philadelphia, a world authority on tissue immunity. He collaborated with Peter Brian Medawar, of London, who won the Nobel Prize in Medicine in 1960.

MILWAUKEE MEDICAL CONFERENCE

Continued from page 47

RHEUMATOID DISEASE AND THE PHYSICIAN

Robert E. Callan, M.D., presiding and moderating

3:00 Variants of Rheumatoid Arthritis, *Lawrence E. Shulman, M.D.*, Johns Hopkins University School of Medicine

3:30 Synovial Fluid Analysis in Rheumatoid Disease, *Gerson C. Bernhard, M.D.*

3:50 Surgical Treatment of Rheumatoid Deformity, *Owen E. Miller, M.D.*

4:10 A Panel Discussion on Rheumatoid Disease, *Gerson C. Bernhard, M.D.*, moderator; panelists, *Lawrence E. Shulman, M.D., Louis Kagen, M.D., Edwin C. Welsh, M.D.*

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*U.S. Patent Nos. 2,565,057-2,695,261

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Facts about

WISCONSIN PHYSICIANS SERVICE

CONFERENCE ON THE EXTENSION OF VOLUNTARY HEALTH INSURANCE

A conference on the extension of voluntary health insurance will be held at State Medical Society headquarters on November 19, 20, 1963. The purpose of this conference is to bring together all organizations interested in the expansion of voluntary health insurance.

Persons attending will be presidents and officers of private and commercial insurance carriers, neighboring Blue Plans, Wisconsin associations, chambers of commerce, industries, labor leaders, legislators, Commission on Medical Care Plans officers, and SMS Councilors.

During the two-day session, prominent speakers will discuss and explore opportunities for research and expansion into added fields of health care, including those relating to benefits for persons chronically ill or in need of short term treatment of mental ailments.

It is hoped that through the leadership of the State Medical Society and other Wisconsin and national organizations, the public will be benefited by an over-all improvement in the quality and extension of health care benefits into every area of the public's health care needs.

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

BOOKS RECEIVED

ESSENTIALS OF PEDIATRIC PSYCHIATRY

By Ruben Meyer, M. D., Associate Professor of Pediatrics, Wayne State University College of Medicine; Attending Pediatrician, Children's Hospital of Michigan; Morton Levitt, Ph. D., Professor of Psychology in Psychiatry and Assistant Dean, Wayne State University College of Medicine; Moredecai L. Falick, M. D., Associate Professor of Psychiatry, Wayne State University College of Medicine; Training Analyst, Psychoanalytic Training Center of Detroit; and Ben O. Rubenstein, Ph. D., Associate Professor of Psychiatry, Wayne State University College of Medicine. Appleton-Century-Crofts, New York, 1962. 208 pages.

STRABISMUS

Symposium of the New Orleans Academy of Ophthalmology: Raynold N. Berke, M. D., Hackensack, N. J.; Harold Whaley Brown, M. D., New York, N. Y.; David G. Cogan, M. D., Boston, Mass.; John Woodworth Henderson, M. D., Ph. D., Ann Arbor, Mich.; Arthur Jampolsky, M. D., San Francisco, Calif., and Marshall M. Parks, M. D., Washington, D. C. Edited by George M. Haik, M. D., New Orleans, La., Diplomate, American Board of Ophthalmology; Professor of Ophthalmology and Head of the Department, Louisiana State University School of Medicine, New Orleans, La.; Ophthalmic Surgeon, American College of Surgeons; Member, American Ophthalmological Society; Member, American Academy of Ophthalmology and Otolaryngology. The C. V. Mosby Company, St. Louis, 1962. 369 pages. Price: $18.00.

PRIMER OF CLINICAL MEASUREMENT OF BLOOD PRESSURE

By George E. Burch, M. D., Henderson Professor of Medicine, Tulane University School of Medicine, New Orleans, La.; Physician-in-Chief in Medicine, Tulane Unit of the Charity Hospital of New Orleans, New Orleans, La.; Consultant in Medicine and Cardiology, Veterans Administration Hospital, Touro Infirmary, Hotel Dieu Hospital, Mercy Hospital, and Ochsner Foundation Hospital, New Orleans, La., and Nicholas P. DePasquale, M. D., Instructor in Medicine, Tulane University School of Medicine, New Orleans, La.; Visiting Physician, Tulane Unit of The Charity Hospital, New Orleans La. The C. V. Mosby Company, St. Louis, 1962. 141 pages. Price: $5.50.

WORKS OF THE INSTITUTE OF HIGHER NERVOUS ACTIVITY

Physiological series, Volume 3. Translated from Russian by M. Roublev. Published for the National Science Foundation. Washington, D. C., and the Department of Health, Education and Welfare by the Israel program for Scientific Translations, Jerusalem, 1961. 263 pages. Available from The Office of Technical Services, U. S. Department of Commerce, Washington 25, D. C. Price: $2.75.

THE BIOLOGICAL ROLE OF NUCLEIC ACIDS

By O. P. Chepinoga. Translated from Russian by Y. Halperin. Published for the National Science Foundation, Washington, D. C., and the Department of Health, Education and Welfare by the Israel Program for Scientific Translations, Jerusalem, 1962. 157 pages. Available from The Office of Technical Services, U. S. Department of Commerce, Washington 25, D. C. Price: $1.50.

ENZYMES AND DRUG ACTION

Ciba Foundation Symposium. Sponsored jointly with Coordinating Committee for Symposia on for the Coordinating Committee, and A. V. S. de Drug Action. Edited by J. L. Mongar, Ph. D., Reuck, M. Sc., D. I. C., for the Ciba Foundation, with 90 illustrations. Little, Brown and Company, Boston, 1962. 556 pages. Price: $12.50.

PROBLEMS OF CYTOLOGY AND PROTISTOLOGY

Collection of articles translated from Russian by Dr. M. Artman and S. Shoshan, M. Sc. Published for the National Science Foundation, Washington, D. C, and the Department of Health, Education and Welfare by the Israel Program for Scientific Translations, Jerusalem, 1961. 372 pages. Available from The Office of Technical Services, U. S. Department of Commerce, Washington 25, D. C. Price: $3.75.

BOOK REVIEWS

SMOKING AND HEALTH

By Alton Ochsner, M. D., Julian Messner, Inc., New York, 1959 (enlarged and revised version of *Smoking and Cancer,* c1954). 108 pages.

An amazing, detailed, anti-smoking appeal presented in lay language with a myriad of references. Dr. Ochsner leaves no doubt where he stands except as a finished writer. The book is hastily thrown together, but this does not detract from the logical reasons (and experiments) he presents on why heavy smoking and good health are not compatible. Smokers should take advantage of the arguments as motivation to quit the habit.—R. J. SAMP, M.D.

HEALTH EDUCATION

Edited by Bernice R. Moss, Ed. D., Professor of Health Education, University of Utah, Editor; Warren H. Southworth, Dr. P. H., Professor of Health Education, University of Wisconsin, Associate Editor; John Lester Reichart, M. D., Chicago, Illinois, Associate Editor, National Education Association of the United States, Washington, D. C., 1961. 429 pages.

This book is developed by editors, contributors and consultants, all of whom are experienced in

the field of education and particularly as it applies to health. The subject matter is divided into 16 chapters, each one containing material concerning various phases of education as it relates to health.

The first chapter is entitled "Health Education" and the last one "Adult Education." Between these two chapters the aspects of education as it applies to special groups—kindergarten to college and university, childhood to old age—and methods of organization are presented in an informative and realistic manner. The discussions of curriculum design will be of special interest to those engaged in teaching organized study groups.

The index affords easy access to subject matter and each chapter is accompanied by an extensive bibliography.

Teachers in all fields of Public Health Welfare will find this helpful and useful for reference material.—WILLIAM D. STOVALL, M. D.

TEXTBOOK OF OTOLARYNGOLOGY

By David D. DeWeese, M. D., Clinical Professor of Otolaryngology, University of Oregon Medical School, Portland, Oregon. William H. Saunders, M. D., Associate Professor of Otolaryngology, The Ohio State University College of Medicine, Columbus, Ohio. The C. V. Mosby Co., St. Louis, Mo., 1960. 464 pages.

This textbook is, as the preface states, designed primarily for the medical student and the general practitioner. As is true of most good texts in this category, the specialist will find it a valuable addition to his library.

Chapter 1, "The Physical Examination," is taken from Saunders in *Physical Diagnosis*, by Prior and Silberstein, and remains one of the best and most basic presentations of this subject to be found anywhere. Emphasis is placed on the special instruments and techniques required to examine the ears, nose and throat.

Certain chapters deserve special mention. The chapter on "Nosebleed" is highly practical, and describes step by step procedures for coping with this often distressing condition. Chapters are devoted to such neglected subjects as speech disorders, rehabilitation of persons with hearing loss, the facial nerve, and the salivary glands. Newer concepts are covered which, especially in the field of surgery of the ear, have tremendously broadened and stimulated the specialty.

It seems a safe prediction that within a short time this book will be the standard medical student text in the subject of Otolaryngology.—R. T. FIRKINS, M. D.

CIBA FOUNDATION SYMPOSIUM ON CONGENITAL MALFORMATIONS

Edited by G. E. W. Wolstenholme, M. D., M. B., M.R.C.P., and Cecilia M. O'Connor, B. Sc. Little, Brown & Co., Boston, Mass., 1960. 308 pages. Price: $9.00.

With the current publicity being given to drug-induced malformations in human fetuses, especially those induced by the drug Thalidomide, this book appears as a well-edited source of information for the use of physicians as well as enlightened laymen.

This book comprises the proceedings of a Symposium on "Congenital Malformations" held in January, 1960. The complete texts of 12 papers read at the Symposium are to be found in the volume. In addition, the complete discussion after each paper is recorded as well as a general discussion at the end of the conference. The topics include such varied subjects as the epidemiology of malformations, chromosomal abnormalities, environmental factors, and maternal factors in teratology.

In the first paper, McKeown and Record describe the incidences of human malformations in a large series collected from Birmingham, England. Their findings suggest interesting associative relationships governed by sex, multiplicity of births, etc. In the next two chapters, mongolism is considered in some detail, including one case having a complement of 46 chromosomes. This was shown to be the probable result of a reciprocal translocation. It is in the area of the trisomyes that the book suffers for lack of more modern information. This is probably a result of the rapid progress made in the field within the past two years as a result of the work of Patau and others. Ingalls next discusses some environmental factors in teratogenesis, such as toxic agents (CO, etc.) and infectious diseases. The three papers following this deal with drugs as teratogenic agents. In particular some of the anti-cancer agents such as fluorouracil and actinomycin D are presented as potential hazards in this field, an important factor in the therapy of a pregnant woman suffering from cancer. Woollam and Millen next present experimental evidence of the benefit of thyroxine in modifying some conditions produced by teratogenic regimens. This data is later expanded somewhat by Hoet et al. to include humans. The importance of looking for and controlling "latent" diabetes in the pregnant woman is emphasized by these authors. The discussions at the end of each paper add to the text in both a critical and informative manner.

The papers are well written, easily readable, and the discussions tend to bring them into a more coherent framework, like the chapters of a text rather than individual scientific accomplishments. Today our expanded knowledge of the mechanism of action of some teratogens as well as the newer trisomy syndromes make some of the book appear out of date to the scientist actively engaged in research. However, for the practicing obstetrician or general practitioner, this book can be an invaluable aid to reviewing facts which are in the public eye as well as a valuable addition in its own right to any library.—HENRY C. PITOT, M. D., Ph. D.

PROBLEMS IN SURGERY

By Frank Glenn, M. D., Lewis Atterbury Stimson Professor of Surgery, Cornell University Medical College, New York, N. Y.; Surgeon-in-Chief, The New York Hospital–Cornell Medical Center, New York, N. Y. Edited by George E. Wantz, Jr., M. D., Assistant Professor of Clinical Surgery, Cornell University Medical College, New York, N. Y.; Assistant Attending Surgeon, The New York Hospital–Cornell Medical Center, New York, N. Y. C. V. Mosby Co., St. Louis, Mo., 1961. 512 pages. Price: $16.50.

The material covered in this volume is from the New York Hospital–Cornell Medical Center's weekly presentation of interesting cases. A total of 152 cases are presented. The cases are chiefly those of general surgery but include orthopedics, cardiovascular surgery, neurosurgery and, to a lesser extent, the other subspecialties. Cases are presented with brief resumes of history, physical and laboratory findings.

The discussion of the patient then brings out the thought processes and approaches of the various staff members at this medical center. The procedures and findings are discussed and the decision and outcomes summarized. There are no detailed discussions on forms of therapy.

The book is well written, concise and to the point, and well illustrated, although the reproductions of x-rays leave something to be desired. Doctor Wantz has added several selected references at the end of each case discussion which adds greatly to the value of the book. The book is easy to read and gives numerous pertinent points by many authoritative clinicians.—HAROLD E. FROMM, M. D.

PROGESTERONE AND THE DEFENSE MECHANISM OF PREGNANCY

Ciba Foundation Study Group No. 9. In honor of Dr. G. W. Corner. Edited by G. E. W. Wolstenholme, O. B. E., M. A., M. B., M. R. C. P., and Margaret P. Cameron, M. A., Little, Brown & Co., Boston, Mass., 1961. 108 pages.

"Progesterone and the Defense Mechanisms of Pregnancy" is the ninth in a series of symposiums conducted by the CIBA Foundation. This symposium consists of 101 pages of interesting presentations and discussions.

The symposium is conveniently broken down into five major categories. The first is a discussion of the Defense Mechanisms of Pregnancy by Arpad Csapo, The Rockefeller Institute. The next section is the Relationship Between Progesterone Production and the Human Placenta and the Fetus by Joseph Zander of the University Frauenklinik, Cologne, Germany. The third section deals with Molecular Aspects of the Contractile Mechanism of the Uterus and its Changes During Pregnancy by D. M. Needham of the University of Cambridge. The fourth chapter deals with the Electrophysiology of the Uterus by Hirosi Kuriyama. The fifth, in summary, is Comments by an Obstetrician, Dr. C. Scott Russell of the University of Sheffield.

This symposium is of special interest to investigators in the field of basic physiology and is also to be recommended to those specialists in the field of obstetrics and gynecology who are particularly interested in the basic physiology of the specialty. Particularly interesting is the combination of a group of basic science investigators and clinicians. Their discussions and points of view are of special interest if only from a philosophical view. Of significant interest from a clinical view is the description of the procedure "salting out", described in some detail by Doctors Bengtsson and Csapo.

In summary, this book is to be recommended for those individuals interested in studying the basic physiology of reproduction and those clinicians who have some background and are interested in basic physiologic investigation.—JOHN C. ELLIS, JR., M. D.

HEREDITY IN OPHTHALMOLOGY

By Jules Francois, Professor of Ophthalmology, University of Ghent, Belgium. C. V. Mosby Co., St. Louis, Mo., 1961. 731 pages. Price: $23.00.

Doctor Jules Francois' book, "Heredity in Ophthalmology," is an informative and concise work. The book is divided into four parts: (1) General Genetics, (2) Genetics in Ophthalmology, (3) The Hereditary Diseases of the Eye, and (4) General Diseases With Ocular Manifestations. The author starts at the beginning of the hereditary consideration and in successive steps takes one from the simplest to the most complex possibility of transmission of inheritance. There are innumerable diagrams and formulae to help the reader visualize and understand the various ways in which heredity manifests itself.

This complex subject is here written in a most understandable manner and this English translation is most admirably done. At the conclusion of each chapter there is a very extensive bibliography which adds considerably to the value of the book. Professor Francois' illustrations are excellent and one could wish that there would be many more of them. However, there is ample illustration and an oversupply could lead to an oversized volume.

"Heredity in Ophthalmology" fills a very definite need, and every ophthalmologist should have a copy of this book in his library for ready reference. —PETER A. DUEHR, M. D.

PATHOLOGY

Edited by W. A. D. Anderson, M. A., M. D., F.A.C.P., F. C. A. P., Professor of Pathology and Chairman of the Dept. of Pathology, University of Miami School of Medicine, and Director of Pathology Laboratories, Jackson Memorial Hospital, Miami, Florida. C. V. Mosby Co., St. Louis, Mo., 1961. 1,388 pages. Price: $18.00.

The Fourth Edition of Anderson's *Pathology* can be recommended to medical students and physicians as an excellently organized and sufficiently detailed text which contains information about most

diseases. Individuals interested in acquiring more information are materially aided by bibliographies compiled at the ends of various chapters.

Whereas the same general organization was retained, most of the chapters have been extensively revised by the various authors contributing to this book. New chapters dealing with hypersensitivity, alterations in collagen and soft tissue tumors have been added. Presentation of many diseases is materially enhanced by schematic illustrations, gross photographs or characteristic microscopic reproductions. This edition cannot do otherwise than sustain and improve the reputation which previous editions of this text have already established.—JOSEPH J. LALICH, M. D.

THE CARDIAC ARRHYTHMIAS

A Guide for the General Practitioner. By Brendan Phibbs, M. D., Casper Clinic, Casper, Wyoming. C. V. Mosby Co., St. Louis, Mo., 1961. 128 pages. Price: $7.50.

The author's basic premise for writing this book is that most texts concerning cardiac arrhythmias are too complicated. Certainly that criticism may not be directed at this book. Some may believe that this has been over simplified and may question the qualification of the author to write such a book. In general, one is willing to accept such marked simplification, homely similies, and dogmatic presentation with repeated personal references only from an unquestioned authority. For practical purposes there are no references. Although the author repeatedly stresses that an electrocardiogram must be taken for diagnosis of all arrhythmias, he fails to make his point other than by dogmatic repetition and several poorly chosen examples in which irrational therapy was given because of failure to take an adequate history.

It is suspected that the casual reader would be better advised to derive his information from more standard and complete sources where he can choose how much information he desires, rather than to try to use this simplified book of limited scope. In general the illustrations are good as they are in any standard electrocardiographic text.—GEORGE G. ROWE, M. D.

ESSENTIAL HYPERTENSION

An International Symposium, Berne, Switzerland, June 7–10, 1960, sponsored by Ciba. Ed. by K. D. Bock, and P. T. Cottier; Chairman, F. C. Reubi. Springer–Verlag, Berlin, Germany, 1960. 392 pages.

This book will be of great value to anyone interested in the problem of hypertension. It consists of 22 papers with full discussion dealing with certain aspects of hypertension of particular current interest. The role of salt intake in the development of hypertension, renal hemodynamics, adrenocortical relationships, pharmacology and therapy are some of the areas covered. The book is highly recommended.—E. C. ALBRIGHT, M. D.

PRINCIPLES OF RADIATION DOSIMETRY

By G. N. Whyte, National Research Council, Ottawa, Canada; Queen's University, Kingston, Ontario. John Wiley & Sons, Inc., New York. 1959. 124 pages.

This book, although small in size, presents a plethora of technical information concerning basic radiation dosimetry. The radiation field is described in detail and basic units are defined. The interaction of radiation with matter is discussed extensively with separate consideration of particulate and electromagnetic radiation.

Comprehensive information is given as to the determination of stopping powers for electrons in matter including evaluation of the "mean excitation potential" of the atoms in the absorbing medium. The relationship between stopping power and the commonly used LET (linear energy transfer) is presented along with graphic illustration of energy loss by electrons in matter. Particulate energy loss by radiation (bremsstrahlung) is discussed with emphasis on the mathematical predictions of energies and angular distributions of the resulting photons.

The bulk of the discussion of particle interaction concerns electrons although information is also presented on alpha particles, protons and neutrons.

Electromagnetic radiation and its interaction with matter is presented with mathematical expressions presented for the resulting distributions. Consideration is given to attenuation of x-rays in matter including the common "broad beam" situation.

The absolute measurement of x-ray intensity by calorimetric and ionization methods is discussed along with comparisons between the two approaches. Exposure dose measurements utilizing the "free air" and the "cavity" type chambers are presented with considerable elaboration on the effect of the chamber wall material.

Measurements of absorbed dose by the calorimetric method, cavity ionization and the extrapolation chamber are discussed with expressions given to determine absorbed dose in biological systems from exposure dose in air.

Charged particle dosimetry is presented with illustration to a faraday cage type measurement and a complete chapter is devoted to neutron dosimetry.

The closing chapter is devoted to secondary instruments such as cavity chambers, geiger and scintillation counters, photographic films and chemical dosimeters with comment on uses in exposure and absorbed dose measurements.

In my opinion this is a highly competent book presenting very basic principles of radiation dosimetry. This book should be of interest and benefit to the radiotherapist as well as to radiation physicists.—GORDON N. KENNEY, B. A.

Classified Advertisements

Advertisements in this section are accepted in two categories: PHYSICIANS' EXCHANGE and COMMERCIAL.

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PHYSICIANS' EXCHANGE

FOR SALE: GENERAL PRACTICE in industrial city of approximately 50,000 in central Wisconsin. Fully staffed, fully manned 275-bed open staff hospital. Good recreational facilities. Should gross $35,000 the first year. Contact Dept. 64 in care of the Journal. m8tfn

FOR SALE: Established EENT practice, over 40 years in the heart of Milwaukee. Excellent referrals; will introduce; retiring. Contact Dept. 24 care of the Journal. m12tfn

OFFICE SPACE for two or three physicians, OB or two surgeons. To rent or to sell. Pharmacy in same building. Contact Dept. 33 in care of the Journal. m3tfn

WANTED: GENERAL PRACTITIONER as associate. Immediately available opportunity to practice in well established group of two. Replacement for sudden loss of partner. Eventual partnership. 126 E. Main Street, Madison. AL 6–3171. m9tfn

WANTED: GENERAL PRACTITIONER as a replacement in town of 1,275 in southern Wisconsin. Gross receipts $42,000 in 1961, over $24,000 first 6 months 1962. Unopposed, good schools, churches, roads, fishing. Nearby accredited 200 bed hospital. Leaving for residency. Contact: D. L. Minter, M.D., Clinton, Wis. m9tfn

WANTED: PHYSICIAN with military service fulfilled to associate with a general surgeon also in general practice in northeastern Wisconsin in a city of 75,000. Excellent salary leading to early partnership. This is an A-1 financial opportunity. An early interview is appreciated. Contact Dept. 43 in care of the Journal. m4tfn

TWO DOCTORS WANTED

Here's what awaits two general practitioners who locate in Brillion, Wisconsin, this fall: A newly constructed, fully equipped $90,000 clinic, as well as two brand new residences; a community of 1,800—located in the "milk vein of the world"—only minutes from the Fox River Valley, Lake Michigan, and Green Bay. Brillion has three major industries, whose payroll is in excess of $4,000,000 a year. The needs of these firms alone will easily support two doctors. Earning potential, living, and working conditions are above average with access to fishing, hunting, and golfing. Write or phone Oliver C. Wordell, c/o Brillion Iron Works, Inc., Brillion, Wisconsin.

WANTED: INTERNIST, Board certified, to join two established surgeons. Excellent office facilities. Opposite 300-bed hospital—200-bed added expansion in progress. Town of 15,000. Central Wisconsin. Guaranteed salary. Percentage and partnership early prospects. Contact Paul F. Doege Medical Center, 512 St. Joseph Ave., Marshfield, Wis. m3tfm

WANTED: GENERAL PRACTITIONER for association with two-man group located near Madison. Excellent hospital and recreational facilities. Salary open to start with partnership opportunity at end of one year. New building with excellent equipment and personnel. Contact Dept. 52 in care of the Journal. m4tfn

GENERAL PRACTICE FOR SALE. Physician desiring own x-ray equipment may purchase radiographic, fluoroscopic and therapy equipment. Seven-room office on main corner in southern Wisconsin city of 35,000 occupied for over 40 years. Wish to retire. Reasonable price. Contact Dept. 19 in care of the Journal. m11tfn

PARTNER IN GENERAL PRACTICE WANTED in Green Lake county, town of 5,000. Fifty-bed private hospital. Five grade schools and one high school. No predominant nationalities. Various churches. Main occupations are leather, fur and metal. Contact Dept. 20 in care of the Journal. m11tfn

STOPPED MEDICAL PRACTICE, ill health. For sale: Burdick EKG; high speed centrifuge, hematocrit centrifuge; steel office furniture, all new since 1957; office instruments; one repaired Hamilton table and cabinet; one new Hamilton cabinet; steel shelving etc.; and hydraulic table. John A. Booher, M.D., Reedsburg. m9tfn

EXCELLENT OPPORTUNITY for PSYCHIATRIST or physician interested in psychiatry to become associated with Mendota Hospital medical team. Permanent Civil Service position with associated benefits. Salary $1,000 and upward per month, depending upon experience and training. Housing available at nominal charge. Regular work hours. Staffed by about 30 psychiatrists and/or physicians. Investigate now. W. J. Urben, Superintendent, Mendota State Hospital, Madison 4, Wis. g9tfn

FOR SALE· GENERAL PRACTICE. In beautiful northeastern Wisconsin where two doctors are covering potential of 10,000 people. Drastic need of a doctor, preferably two, to take over the practice of deceased physician. Office has large waiting room, two consultation rooms, examining room, two treatment rooms, laboratory, and library. A pharmacy is adjacent to the building. Equipment of the highest quality and TRAINED PERSONNEL ready to help you. Good hospital in town. Practice has great surgery potential. Townspeople will help you if you are the right person. Contact Mrs. H. A. Aageson, Oconto, Wis. Please supply references with your reply. m9–11

URGENTLY NEEDED: Associate going for residency—another man urgently needed. Twelve miles east of Fond du Lac, Catholic rural area. Start at $1,300 or more monthly. No investment. Available June. Contact Jos. F. Miller, M.D., Mt. Calvary, Wis. m4tfn

WANTED: INTERNIST, Board certified or eligible for association with young internist in southeastern Wisconsin city of 90,000. Contact Dept. 980 in care of the Journal. m4tfn

FOR SALE: IN WISCONSIN. General practice, well established, same location 40 years, fully equipped 7-room office. Will take any reasonable offer and finance as you wish. Poor health forces retirement. Contact Dept. 912 in care of the Journal. m4tfn

WANTED: PHYSICIAN to share a clinic which is now occupied by an M.D. and a D.D.S., located in a prosperous southeastern Wisconsin industrial and farming community where the need for another physician is very great. Contact Dept. 827 in care of the Journal. 4tfn

FOR SALE: PEDIATRICS PRACTICE in suburb of large Wisconsin city; will introduce; buyer assume two-year lease; open hospital staff; physician leaving Sept. 1, 1962, for academic post. Contact Dept. 985 in care of the Journal. m5tfn

FOUR-ROOM SUITE plus use of large, pleasant waiting room available in air-conditioned, modern allergy clinic. ENT or medical man (GP?)-(Pediatrician?) would find space unusually advantageous. Adjacent Capitol Court Shopping Center, northwest Milwaukee area. Contact Dept. 67 in care of the Journal. m9tfn

OFFICE SPACE in medical clinic, 2218 North Third Street, Milwaukee, Wis.; Co. 4–2800. m3tfn

WANTED: GENERAL PRACTITIONER to replace physician who left for residency training. Fully equipped office available immediately. Town of 2,100 offers good hospital, skiing, hunting, golf, fishing and many other recreational advantages along the Chippewa River near its junction with the Mississippi. Financial remuneration should be excellent from the start. Contact Dept. 7 in care of the Journal. m9tfn

WANTED: GENERAL PRACTITIONER for associate with two other general practitioners in community of 2,400 with trade area of 7,000 in Green county. No investment required. Excellent clinical and diagnostic facilities. 200 bed hospital 15 miles. Good educational facilities. Convenient communications to recreational areas. Contact M. W. Stuessy, M.D., Brodhead. m3tfn

GENERAL PRACTICE available immediately in Milwaukee, Wis. (southeast side). Established 35 years, busy active practice, excellent location, beautiful ground floor clinic building, air-conditioned. Contact Dept. 41 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER. Must be graduate of class A medical school, preferably with two-year internship from class A teaching hospital. Midwest industrial city of 46,000. Open staffed, fully equipped, 250-bed hospital. Equal partnership if satisfactory within two years. Excellent recreational facilities. Have well established general practice. Contact Dept. 57 in care of the Journal. m5tfn

WANTED: OB–GYN physician and a general practitioner with some general surgical training to associate with another physician. Beautiful, large, new, well-equipped office. Parking lot. Air-conditioned. Starting salary $1,000. Partnership. City 10,000; drawing area 20,000. North Central Wisconsin. Contract Dept. 46 in care of the Journal. m4tfn

WANTED: GENERAL SURGEON, well qualified, to join two man clinic group in community of 40,000. Excellent facilities and limitless opportunity. State qualifications and availability when contacting Dept. 61 in care of the Journal. m7tfn

GENERAL SURGEON, Board certified, age 33, considers relocating; prefers solo practice but would consider group; am thinking of smaller community (20,000 or less) that will support surgical specialist. Contact Dept. 69 in care of the Journal. m9–10

GOOD LOCATION AVAILABLE for general practitioner. Nothing to buy. Will assist and refer all general practice cases. Contact C. A. Sholtes, M.D., Richland Center, Wis., Midway 7–2592 or 7–2544. m9tfn

FOR SALE: GENERAL PRACTICE, well trained and active, in new fully equipped clinic building. Present physician leaving for residency. Personnel well trained and efficient. Rural village 38 miles northeast of Madison. New school, swimming pool, good housing available. Subsidy can be arranged through village. Contact Joseph G. Brown, M. D., Cambria, Wisconsin. m6tfn

FOR SALE: GENERAL PRACTICE in Chippewa Falls, Wis.; well established, same location for 17 years, fully equipped 5½-room office. Will take any reasonable offer and finance as you wish. Office help available. Practice available because of recent death of William F. Janc, M.D. Contact Mrs. William F. Janc, 300 Macomber Street, Chippewa Falls, Wis. m7tfn

MEDICAL SUITE: Thiensville–Mequon Medical Center Building, Thiensville, Wisconsin. Two doctors' offices, four examining rooms, lead lined x-ray room, laboratory, general office and waiting room. Heating and air conditioning furnished by owner. Available Nov. 1, 1963. Phone Chestnut 2–1080 or Chestnut 2–2344. E. C. Neidner, 231 South Main Street, Thiensville, Wisconsin. 5tfn

WANTED: GENERAL PRACTITIONER as associate in a four-man group with adequate clinical facilities. Offer open for two or three year locum tenens or for permanent association in the group. Town of 4,000, well-equipped 80-bed hospital, in west central Wisconsin. Contact Dept. 10 in care of the Journal. m9tfn

EENT SPECIALIST NEEDED for Eau Claire and vicinity, population 60,000. Could take over 20-year practice of deceased physician. Very advantageous opportunity. Contact Mrs. S. B. Russell, 114½ Grand Avenue West, Eau Claire, Wis. m3tfn

WANTED: USED EQUIPMENT of a physician. Young physician establishing private practice in Madison interested. Contact Dept. 34 in care of the Journal. m3tfn

WANTED: GENERAL PRACTITIONER or internist to take over immediately a large established practice on new northwest side of Milwaukee. Practice and office could accommodate two doctors if desired. New medical clinic building with all modern features includes private parking area, business office, large private office, four examining rooms, x-ray and laboratory facilities. Contact Dept. 56 in care of the Journal. m5tfn

GROUP OF THREE desires general practitioner as associate. New clinic building with adequate facilities, in town of 5,500. Recent graduate preferable. Contact Plymouth Clinic, Plymouth, Wis. m4tfn

LOCATION WANTED: Either general practice or radiology or combination. Board eligible in radiology and experienced GP. Will serve several small hospitals in radiology, or will purchase retiring physician's equipment. Contact Dept. 51 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER, immediate full partnership in active practice now grossing $50,000, all advantages of dual practice with vacation periods and free weekends. No investment required. Full hospital privileges. Contact Dept. 53 in care of the Journal. m4tfn

WANTED: A two man partnership would like a general practitioner interested in internal medicine or an internal medicine man to become associated. Location is in north central Wisconsin. New hospital facilities are available as well as a large extensively equipped office. Contact Dept. 59 in care of the Journal. m7tfn

GENERAL PRACTITIONER for psychiatric treatment center. Excellent working conditions. Starting pay from $12,000 to $15,600 based on experience and training. State Civil Service status with associated benefits. Forty-hour week, paid holidays, vacation, retirement fund. Some on grounds housing for single, or small families. Hospital location on beautiful 300-acre Lake Mendota frontage site. Contact Dr. W. J. Urben, Superintendent, Mendota State Hospital, Madison 4, Wis. g9tfn

UNUSUAL OPPORTUNITY in unopposed solo practice in Wyoming, Iowa (Jones County), due to sudden death of only physician. Short distances to three hospitals. Air-conditioned house-office combination available if desired. Prosperous rural area. Collections 95%. Address inquiries to Mrs. C. R. Smith, Wyoming, Iowa. Phone HUbbard 8-3230. p8-9

OUTSTANDING OPPORTUNITY for a young physician who is willing to work. Good schools, good 100-bed hospital. Good fishing and hunting. Retiring. Contact Dept. 32 in care of the Journal. m7-9

FOR SALE: GENERAL PRACTICE in Prairie du Sac, Wis.; well established, same location for 15 years in fully equipped 4 room suite of offices, including small unit x-ray machine; ground floor clinic building, balance of space rented to dentist. Same office help for 15 years. Hospital facilities available in community, a rural village 27 miles northwest of Madison. New school, swimming pool and housing available. Office building and equipment may be purchased or rented. Practice available because of recent death of Milton Trautmann, M.D. Contact Mrs. Esther F. Trautmann, Prairie du Sac, Wis., or Attorney R. F. Curtin, Box 36, Sauk City, Wis. m9tfn

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WANTED: PEDIATRICIAN for two-man department in 13-man multi-specialty group located in southern Wisconsin city of 37,000. Salary first two years, then share in profit. Excellent retirement and vacation policy. Contact Dept. 58 in care of the Journal. 6-11

WANTED: GENERAL PRACTITIONER or man with specialty who will do general practice and associate with one or two other men in well established practice. Fox River Valley. Immediate opening. Community of 50,000. Salary two years, then partnership. Contact Dept. 38 in care of the Journal. m4-5

WANTED: OPHTHALMOLOGIST for newly organized group in the Fox River Valley of Wisconsin. Community of over 50,000. Excellent living conditions, noted recreational area and above average opportunity. Salary two years then partnership. Contact Dept. 45 in care of the Journal. 4tfn

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WANTED: GENERAL PRACTITIONER to join general practitioner in well established practice in southeastern Wisconsin. Town of 8,000. Class A accredited hospital. Salary or partnership if mutually agreeable. Contact Dept. 39 in care of the Journal. m3-5

URGENTLY NEEDED: General Practitioner to become associated with small clinic group in Milwaukee, Wis., preferably one who has had practical experience and a special interest in obstetrics or industrial surgery. First year, salary; then profit percentage leading to partnership. Contact Dept. 48 in care of the Journal. m4tfn

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WANTED: GENERAL PRACTITIONER to replace retired physician in established three-man group. Must be interested in general medicine, obstetrics, and willing to assist in surgery. Fully equipped medical suite including x-ray and laboratory in town of 50,000 in Fox River Valley of Wisconsin. Unusual opportunity with eventual partnership. Contact Dept. 36 in care of the Journal. m3tfn

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PHYSICIAN WANTED: General practitioner in northeastern Wisconsin wants part time help. Can use one man or combination to cover practice for week, month, or up to a year. Money no object for right man. No OB or surgery unless desired. Living facilities and car available. Contact Dept. 29 in care of the Journal. m1tfn

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INTERNIST WANTED for established group in Milwaukee suburb. One year salary then progression to equal ownership. Busy practice, good hospital, and office facilities. Fine opportunity. Contact Dept. 66 in care of the Journal. 9-11

WANTED: PHYSICIAN needed for village in east-central Wisconsin. Excellent schools, churches; in heart of fishing and hunting. Unlimited opportunities for ambitious physician. Contact Dept. 68 in care of the Journal. m9

FOR SALE: Genophthalmic chair, Genophthalmic refractor, Claison projector, eye glass display cabinet, treatment table, records from eye, ear, nose and throat practice—42 years. Price very reasonable. J. J. Sharpe, M.D., 150 E. First St., Fond du Lac; telephone 291 and 349. m3tfn

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WANTED: PHYSICIAN to associate with two established general practitioners in southeastern Wisconsin industrial, agricultural community of 6,000. Prefer one who has had special surgical or obstetrical training and willing to do general practice along with surgery or obstetrics. Contact Dept. 31 in care of the Journal. m1-3tfn

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HELP! Two-man practice with only one man! General practitioner. Small town. Salary first year; partnership later. T. S. Westcott, M.D., 115 West Chestnut St., Pardeeville, Wis. m3tfn

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GENERAL PRACTITIONER desires associate or partner. Liberal terms. No down payment. Two open staff hospitals. Plenty of work and plenty of recreational opportunities. A. B. Kores, M.D., Beaver Dam, Wis. m3tfn

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PLAN FOR PSYCHIATRIC residency for July, 1964? NIMH General Practitioner program: $12,000 yearly, partially tax free. Three-year approved, balanced didactic and clinical training. In Michigan's Vacationland. Dr. Curtis W. Page, Training Director, Traverse City State Hospital, Traverse City, Michigan. 6-10

FOR SALE: American Sterilizer Company autoclave, interior dimensions 8" x 8" x 15½", model 548A. Val V. Quandt, M.D., 57 South Main Street, Hartford, Wis. m7tfn

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GENERAL PRACTITIONER or internist to take over a thriving established practice in new northwest side of Milwaukee. Plan to specialize in one to two years. Office large enough for two physicians with x-ray and laboratory facilities. Willing to turn over entire practice. Equipment can be purchased at cost. Contact Dept. 65 in care of the Journal. m9tfn

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FOR SALE: Microscope (E. Leitz Wetzlar Germany), Stryker cast cutter, medical instruments, Renwal sterilizer, Baumanometer (Kompak model), Detecto doctor scale, Tonsilectome and tips, Bard Parker utility syringe outfit, stethoscope (triple change), Kidde dry ice apparatus. Mrs. Cecile Arnoldussen, 1618 S. Willkie St., Appleton, Wis. m9tfn

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VIRGINIA, MINNESOTA. Pop. 14,000, area pop. 80,000. St. Louis County. OB-GYN specialist wanted on partnership basis with 20 others. Excellent hospital. Office space available in modern clinic with complete laboratory and x-ray service. Living space available in new, modern houses or apartment. Main sources of income in area are farming, taconite, and mining. All churches represented and excellent school. Social activities available, hunting and fishing. Contact Donald L. Werner, M.D., East Range Clinic, Virginia, Minn. 9tfn

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WANTED: GENERAL PRACTITIONER to become associated with small group in central Wisconsin, preferably one who has had some practical experience, and has a special interest in obstetrics; also willing to only assist in surgery. Contact Dept. 969 in care of the Journal. m2tfn

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ASSOCIATE WANTED in general practice. $18,000 guaranteed clear per year. Should earn $30,000 clear after two years. Contact Jos. F. Miller, M.D., Mt. Calvary, Wis. m7tfn

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FOR SALE: Air-conditioned first floor office building, 1800 sq. ft., supplemental rental income from three dental offices upstairs. Owner in practice 13 years before leaving, had large, active practice. In city of Mayville, Wis., near Horicon marsh recreational area, state's largest cities for cultural, shopping activities. Open staff hospitals nearby. Contact Mr. Earl Anderson, 607 Seitz Ave., Mayville, Wis. m7tfn

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FOR SALE: Equipment of retiring physician, including National cautery; two Hamilton steeltone examination room suites—one buff, one white; Birtcher crystal bandmaster diathermy, with surgical attachments; accessories; various small instruments and treatment room supplies. Contact Mr. Harvey Schellpfeffer, 44 N. Main St., Mayville, Wis. m7tfn

URGENTLY NEEDED: Associate going for residency—another man urgently needed. Twelve miles east of Fond du Lac, Catholic rural area. Start at $1,300 or more monthly. No investment. Available June. Contact Jos. F. Miller, M.D., Mt. Calvary, Wis. m4tfn

WANTED: INTERNIST, Board certified or eligible for association with young internist in southeastern Wisconsin city of 90,000. Contact Dept. 980 in care of the Journal. m4tfn

FOR SALE: IN WISCONSIN. General practice, well established, same location 40 years, fully equipped 7-room office. Will take any reasonable offer and finance as you wish. Poor health forces retirement. Contact Dept. 912 in care of the Journal. m4tfn

WANTED: PHYSICIAN to share a clinic which is now occupied by an M.D. and a D.D.S., located in a prosperous southeastern Wisconsin industrial and farming community where the need for another physician is very great. Contact Dept. 827 in care of the Journal. 4tfn

FOR SALE: PEDIATRICS PRACTICE in suburb of large Wisconsin city; will introduce; buyer assume two-year lease; open hospital staff; physician leaving Sept. 1, 1962, for academic post. Contact Dept. 985 in care of the Journal. m5tfn

FOUR-ROOM SUITE plus use of large, pleasant waiting room available in air-conditioned, modern allergy clinic. ENT or medical man (GP?)-(Pediatrician?) would find space unusually advantageous. Adjacent Capitol Court Shopping Center, northwest Milwaukee area. Contact Dept. 67 in care of the Journal. m9tfn

OFFICE SPACE in medical clinic, 2218 North Third Street, Milwaukee, Wis.; Co. 4–2800. m3tfn

WANTED: GENERAL PRACTITIONER to replace physician who left for residency training. Fully equipped office available immediately. Town of 2,100 offers good hospital, skiing, hunting, golf, fishing and many other recreational advantages along the Chippewa River near its junction with the Mississippi. Financial remuneration should be excellent from the start. Contact Dept. 7 in care of the Journal. m9tfn

WANTED: GENERAL PRACTITIONER for associate with two other general practitioners in community of 2,400 with trade area of 7,000 in Green county. No investment required. Excellent clinical and diagnostic facilities. 200 bed hospital 15 miles. Good educational facilities. Convenient communications to recreational areas. Contact M. W. Stuessy, M.D., Brodhead. m3tfn

GENERAL PRACTICE available immediately in Milwaukee, Wis. (southeast side). Established 35 years, busy active practice, excellent location, beautiful ground floor clinic building, air-conditioned. Contact Dept. 41 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER. Must be graduate of class A medical school, preferably with two-year internship from class A teaching hospital. Midwest industrial city of 46,000. Open staffed, fully equipped, 250-bed hospital. Equal partnership if satisfactory within two years. Excellent recreational facilities. Have well established general practice. Contact Dept. 57 in care of the Journal. m5tfn

WANTED: OB–GYN physician and a general practitioner with some general surgical training to associate with another physician. Beautiful, large, new, well-equipped office. Parking lot. Air-conditioned. Starting salary $1,000. Partnership. City 10,000; drawing area 20,000. North Central Wisconsin. Contract Dept. 46 in care of the Journal. m4tfn

WANTED: GENERAL SURGEON, well qualified, to join two man clinic group in community of 40,000. Excellent facilities and limitless opportunity. State qualifications and availability when contacting Dept. 61 in care of the Journal. m7tfn

GENERAL SURGEON, Board certified, age 33, considers relocating; prefers solo practice but would consider group; am thinking of smaller community (20,000 or less) that will support surgical specialist. Contact Dept. 69 in care of the Journal. m9–10

GOOD LOCATION AVAILABLE for general practitioner. Nothing to buy. Will assist and refer all general practice cases. Contact C. A. Sholtes, M.D., Richland Center, Wis., Midway 7–2592 or 7–2544. m9tfn

FOR SALE: GENERAL PRACTICE, well trained and active, in new fully equipped clinic building. Present physician leaving for residency. Personnel well trained and efficient. Rural village 38 miles northeast of Madison. New school, swimming pool, good housing available. Subsidy can be arranged through village. Contact Joseph G. Brown, M. D., Cambria, Wisconsin. m6tfn

FOR SALE: GENERAL PRACTICE in Chippewa Falls, Wis.; well established, same location for 17 years, fully equipped 5½-room office. Will take any reasonable offer and finance as you wish. Office help available. Practice available because of recent death of William F. Janc, M.D. Contact Mrs. William F. Janc, 300 Macomber Street, Chippewa Falls, Wis. m7tfn

MEDICAL SUITE: Thiensville–Mequon Medical Center Building, Thiensville, Wisconsin. Two doctors' offices, four examining rooms, lead lined x-ray room, laboratory, general office and waiting room. Heating and air conditioning furnished by owner. Available Nov. 1, 1963. Phone Chestnut 2–1080 or Chestnut 2–2344. E. C. Neidner, 231 South Main Street, Thiensville, Wisconsin. 5tfn

WANTED: GENERAL PRACTITIONER as associate in a four-man group with adequate clinical facillties. Offer open for two or three year locum tenens or for permanent association in the group. Town of 4,000, well-equipped 80-bed hospital, in west central Wisconsin. Contact Dept. 10 in care of the Journal. m9tfn

EENT SPECIALIST NEEDED for Eau Claire and vicinity, population 60,000. Could take over 20-year practice of deceased physician. Very advantageous opportunity. Contact Mrs. S. B. Russell, 114½ Grand Avenue West, Eau Claire, Wis. m3tfn

WANTED: USED EQUIPMENT of a physician. Young physician establishing private practice in Madison interested. Contact Dept. 34 in care of the Journal. m3tfn

WANTED: GENERAL PRACTITIONER or internist to take over immediately a large established practice on new northwest side of Milwaukee. Practice and office could accommodate two doctors if desired. New medical clinic building with all modern features includes private parking area, business office, large private office, four examining rooms, x-ray and laboratory facilities. Contact Dept. 56 in care of the Journal. m5tfn

GROUP OF THREE desires general practitioner as associate. New clinic building with adequate facilities, in town of 5,500. Recent graduate preferable. Contact Plymouth Clinic, Plymouth, Wis. m4tfn

LOCATION WANTED: Either general practice or radiology or combination. Board eligible in radiology and experienced GP. Will serve several small hospitals in radiology, or will purchase retiring physician's equipment. Contact Dept. 51 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER, immediate full partnership in active practice now grossing $50,000, all advantages of dual practice with vacation periods and free weekends. No investment required. Full hospital privileges. Contact Dept. 53 in care of the Journal. m4tfn

WANTED: A two man partnership would like a general practi'ioner interested in internal medicine or an internal medicine man to become associated. Location is in north central Wisconsin. New hospital facilities are available as well as a large extensively equipped office. Contact Dept. 59 in care of the Journal. m7tfn

GENERAL PRACTITIONER for psychiatric treatment center. Excellent working conditions. Starting pay from $12,000 to $15,600 based on experience and training. State Civil Service status with associated benefits. Forty-hour week, paid holidays, vacation, retirement fund. Some on grounds housing for single, or small families. Hospital location on beautiful 300-acre Lake Mendota frontage site. Contact Dr. W. J. Urben, Superintendent, Mendota State Hospital, Madison 4, Wis. g9tfn

UNUSUAL OPPORTUNITY in unopposed solo practice in Wyoming, Iowa (Jones County), due to sudden death of only physician. Short distances to three hospitals. Air-conditioned house-office combination available if desired. Prosperous rural area. Collections 95%. Address inquiries to Mrs. C. R. Smith, Wyoming, Iowa. Phone HUbbard 8-3230. p8-9

OUTSTANDING OPPORTUNITY for a young physician who is willing to work. Good schools, good 100-bed hospital. Good fishing and hunting. Retiring. Contact Dept. 32 in care of the Journal. m7-9

FOR SALE: GENERAL PRACTICE in Prairie du Sac, Wis.; well established, same location for 15 years in fully equipped 4 room suite of offices, including small unit x-ray machine; ground floor clinic building, balance of space rented to dentist. Same office help for 15 years. Hospital facilities available in community, a rural village 27 miles northwest of Madison. New school, swimming pool and housing available. Office building and equipment may be purchased or rented. Practice available because of recent death of Milton Trautmann, M.D. Contact Mrs. Esther F. Trautmann, Prairie du Sac, Wis., or Attorney R. F. Curtin, Box 36, Sauk City, Wis. m9tfn

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INDEX TO ADVERTISERS

American Tobacco Co. ---- 17
Ames Company, Inc. ---- 69
Barr X-ray Co., The ---- 33
Borden's ---- 50
Burroughs Wellcome & Co., Inc. ---- 38, 53
Chatham Pharmaceuticals, Inc. ---- 16
Davies, Rose & Company, Ltd. ---- 14
Endo Laboratories ---- 34
Fairmont Foods ---- 26
Glenbrook Laboratories ---- 9, 21
Haug Drug Company ---- 36, 39
Hotel Schroeder ---- 16
House of Bidwell, Inc. ---- 33
Hurley X-ray Company ---- 50
Keeley Institute, The ---- 16
Lederle Laboratories ---- 10, 11, 42, 60, 61
Lilly and Company, Eli ---- Front cover, 18
Lov-e Company ---- 20
Medical Protective Company, The ---- 62
Milwaukee Sanitarium Foundation ---- 50
Parke, Davis & Company ---- 2, 3
Physicians' Exchange ---- 65, 66, 67
Rennebohm's ---- 50
Robins Co., Inc., A. H. ---- 15
Roche Laboratories ---- Back cover
Rogers Memorial Hospital ---- 62
Rorer, Inc., Wm. H. ---- 63
Rowley and Schlimgen ---- 4
Sacred Heart Sanitarium ---- 68
St. Croixdale Sanitarium ---- 4
St. Mary's Hill Hospital ---- 64
Searle & Co., G. D. ---- 19
Shorewood Sanitarium ---- 36
Smith Kline & French Laboratories ---- 23
Squibb ---- 35
Time Insurance Company ---- 36
Tutag & Co., S. J. ---- 64
Wallace Laboratories ---- 13, 22, 24, 25, 40, 41, 51
Winthrop Laboratories ---- 6, 49, 52, 59
Wisconsin Physicians Service ---- 54

SACRED HEART SANITARIUM

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An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Fully accredited. Literature and rates sent on request.

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William H. McCreary, Jr., M. D.
Mario M. Oliveira, M. D.

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

CONTENTS

Vol. 62, No. 10 OCTOBER 1963

SCIENTIFIC ARTICLES

Transient and Persistent Duodenal Obstruction Secondary to Acute Pancreatitis, by I. N. Nevin, M. D., Rhinelander 395

Tetanus Infection, by Henry Brown, M. D., Madison 400

Farm Accidents Occurring in Children, by G. L. Lucas, M. D. and H. W. Wirka, M. D., Madison 405

Clinicopathologic Conference, by M. B. Llewellyn, M. D., Janesville 410

Secondary Surgery of a Congenital Esophageal Atresia with Tracheo-Esophageal Fistula, by W. M. Stoll, M. D., Green Bay 416

SPECIAL ARTICLES

Long-Term Blood Preservation—A Reality (abstract) 399

Green County's Adult Tetanus Immunization Clinics 403

Salmonella in the Shell 404

Comments on Treatment: Chemotherapy of Herpes Simplex Virus and Vaccinia Virus, by H. F. Hardman, M. D., Ph. D., Milwaukee 417

Official Call for Scientific Exhibits, 1964 Annual Meeting, Milwaukee, May 11–12–13 24

EDITORIALS

President's Page: Is the Wisconsin State Medical Society the "Conscience of Medicine" in Our State?, by W. J. Egan, M. D., Milwaukee 420

Fair Trade Time Again 422

A Strong Ally 423

REGULAR FEATURES

County Society Proceedings 31

Specialty Society Proceedings 35

News of Wisconsin Physicians 41

Medical Meetings 51

Bookshelf 59

List of Officers of State and County Medical Societies and scheduled meetings of County Medical Societies 65

Physicians' Exchange 67

Index to Advertisers 70

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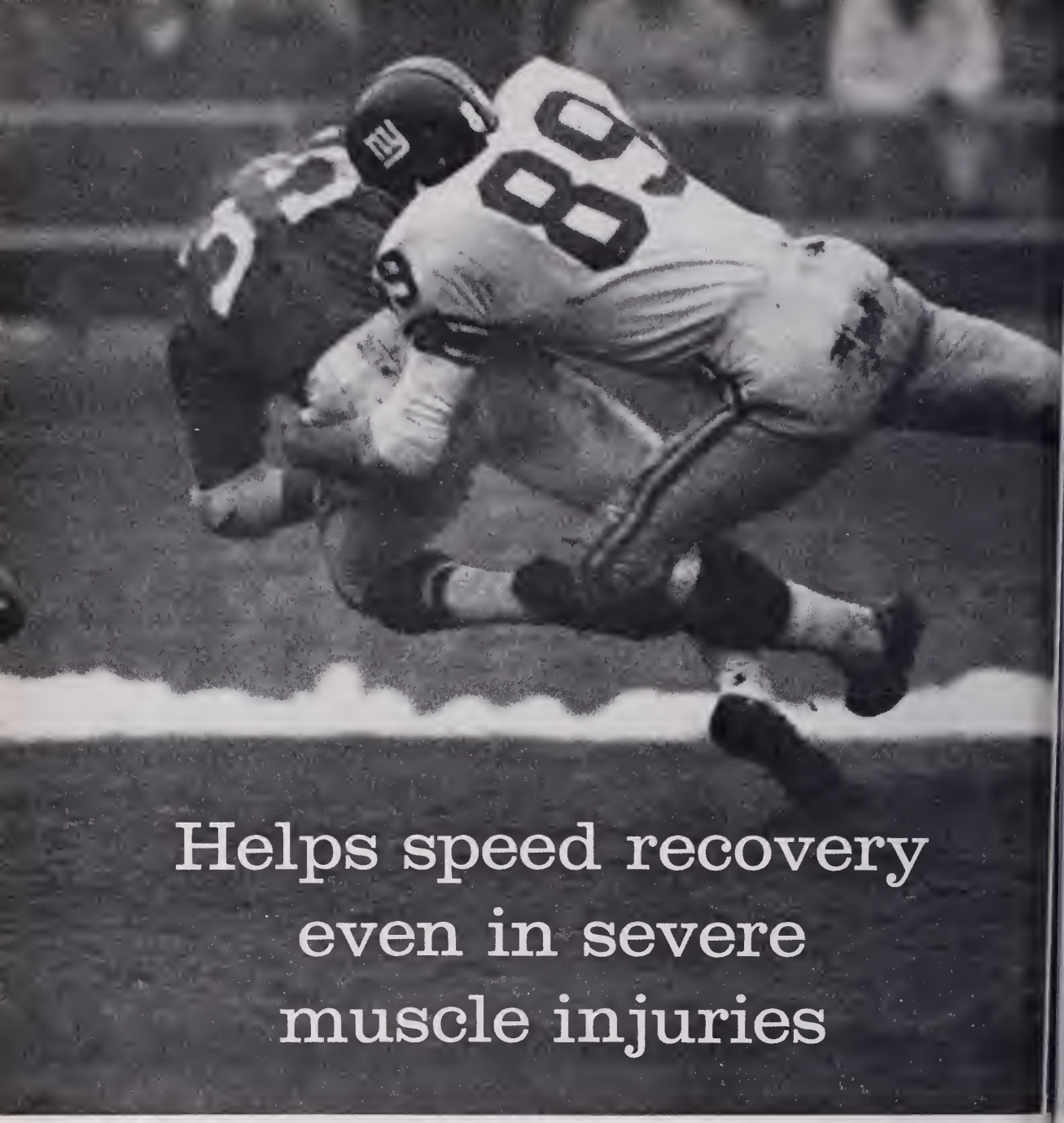
Journal
Established 1903
Annual Subscription.....$6.00
Single Copy..... 1.00
Previous Years'..... 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 303 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.



Whether your muscle-injury patient is a professional athlete or just a weekend golfer, you can expect rapid results with 'Soma' (carisoprodol).

This unique drug breaks up both muscle spasm and pain at the same time. Onset of action takes only 30 minutes, and your patient will usually begin to feel better within hours.

As Conant demonstrated in a study of 106 patients with musculoskeletal injuries, 88% of the patients treated with 'Soma' (carisoprodol) achieved good to excellent results. *(Clinical Medicine*, March, 1962.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely. For severe athletic strains or everyday sprains, you can rely on 'Soma' (carisoprodol) to help spe recovery with notable safety.

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The muscle relaxant with
an independent pain-relieving action

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carisoprodol

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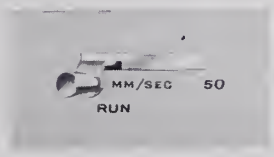
added capabilities in a cardiograph . . . with the Sanborn "100 Viso"



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SANBORN COMPANY
Medical Division, Waltham 54, Mass.

MILWAUKEE *Resident Representative* 743 No. Fourth Street, Broadway 1-3883

OFFICIAL CALL
for Scientific Exhibits

1964 ANNUAL MEETING, MILWAUKEE, MAY 11–12–13

★

The Commission on Scientific Medicine is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1964 Annual Meeting. The exhibits will be located in Bruce Hall of the Milwaukee Auditorium.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space in the 1964 meeting are requested to file an application BEFORE FEB. 1, 1964, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed.

In-state exhibitors will have the following facilities provided by the State Medical Society: Velour booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, special lighting equipment, and half the cost of any drapes rented (rented through Badger Flag and Decorating Company at time exhibit is installed).

Booths for scientific exhibits will have dark maroon velour background, 8′ in height, and 8′ velour side dividers (such as is shown in illustration at right).

No exhibit may exceed a height of 7′ from the floor.

Counters (3′ high and 20″ wide) or tables (30″ high and 3′ wide) are available for viewboxes or displays to be raised above floor level.

Spaces can be allocated in 10′ units.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit by Feb. 1, 1964. *No applications can be accepted after that date.* Address your communications to:

JOHN K. CURTIS, M. D.
Director of Scientific Exhibits
% State Medical Society of Wisconsin
Box 1109
Madison 1, Wisconsin

Use form on following page.

CRAWFORD

Speakers at the Crawford County Medical Society's annual meeting, held in Prairie du Chien, were *Dr. John F. Morrissey*, University of Wisconsin, and *Dr. Jack A. Klieger*, Marquette University. Doctor Morrissey discussed the medical management of peptic ulcers without freezing, and Doctor Klieger discussed the Rh factor in obstetrics. The society was assisted in this program by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

DANE

The annual Dane County Medical Society Golf Tournament was held September 10 at the Maple Bluff Country Club, Madison. Winners were: low gross, *Dr. Frederick J. Davis*, Madison, with a score of 76; *Dr. Phillip J. Schoenbeck*, Stoughton, with a score of 77; and *Dr. Donald A. Peterson*, Madison, with a score of 78. The low net winners, who tied incidently, were: Doctor Schoenbeck and *Dr. Donald S. Schuster*, Madison.

New members of the Dane County Medical Society are noted below.

Dr. Jergen L. Barber was born in Omaha, Neb., and graduated from the University of Nebraska College of Medicine in 1959. He completed his internship at Kansas City General Hospital in Kansas City, Mo., and currently is in resident training in anesthesiology at University Hospitals, Madison.

Dr. Frederick W. Blancke was born in Amsterdam, Netherlands, and received his medical education from University of Amsterdam Medical School where he graduated in 1950. He served his internship at Trinity Lutheran Hospital in Kansas City, Mo., and completed his residency in internal medicine at Menorah Medical Center, Kansas University Medical Center. Prior to coming to Madison, Doctor Blancke practiced in Topeka, Kan., and currently is assistant clinical director at Mendota State Hospital.

Dr. James D. Cherry was born at Summit, N. J., and graduated from the University of Vermont College of Medicine in 1957. He served his internship at Boston City Hospital and completed his residency in pediatrics at Kings County Hospital, Brooklyn, N. Y., as a research fellow in medicine at Harvard Medical School and Thorndike Memorial Laboratory and at Boston City Hospital. Doctor Cherry is director of the John A. Hartford Laboratory, Madison General Hospital, and is an assistant professor of pediatrics at University Hospitals.

Dr. Joseph C. Kiser was born at Middlebourne, W. Va. He graduated from the University of Chicago School of Medicine in 1957 and served his internship at Minneapolis General Hospital. Doctor Kiser has completed his residency in general surgery at Minneapolis General Hospital and is in private practice in Madison.

Physicians whose names appear in italic are members of the State Medical Society.

COUNTY SOCIETY PROCEEDINGS

DOUGLAS

The Douglas County Medical Society met in Superior, on Sept. 4, 1963, at the Saratoga Cafe and Superior State College. Dr. E. J. Ehrenberg of Minneapolis, Minn. spoke on addiction and alcoholism; there were 15 members present. The next meeting was held Oct. 2, 1963, and the Booz, Allen and Hamilton report was discussed.

LA CROSSE

The La Crosse County Medical Society met in La Crosse on Sept. 9, 1963, at the Fireside Restaurant. The Booz–Allen–Hamilton report was discussed. Sixty-seven persons were present. New members added to the Society are *Drs. Wanir C. da Costa*, La Crosse; *George P. Gersch*, West Salem; and *Wilfrido R. Yutuc*, La Crosse. The next meeting will be held Oct. 21.

PIERCE—ST. CROIX

The Pierce–St. Croix County Medical Society met in August at Ellsworth, and in September at North Hudson, it was announced recently by *Dr. P. H. Gutzler*, River Falls, secretary for the society.

RACINE

In an effort to stimulate interest in careers in medicine, the Racine County Medical Society in cooperation with allied professional services had its first booth at the Racine County Fair.

In other news of the society, *Dr. Richard Minton*, Racine, and other members of the Racine County Medical Society were commended for their "enlightened interest" in public health as demonstrated in the recent "Quick Check" of chronic illnesses program. The commendation was made by Dr. Milton Feig, director of the State Board of Health's section on preventable diseases. "Quick Check" was conducted through a mobile unit during April in Racine to detect cases of diabetes, heart disease, lung disease and hypertension. Doctor Minton served as the medical society's chairman for the program, conducted in cooperation with the State Board of Health and the City Health Department.

A letter from Doctor Feig to Doctor Minton commenting on this program appeared in the "Letters" section of the September issue.

ROCK

The Rock County Medical Society was host at a dinner meeting to about 25 Commercial Insurance agents in Beloit, August 27, when the group heard

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Edward Holan, a Madison underwriter, discuss the King–Anderson bill. He systematically and actuarily described how potential life insurance clients would do better with commercial carriers rather than have the present compulsory Social Security program. The meeting was arranged by the county committee set up and operating under the plan "Operation Hometown" sponsored by the American Medical Association.

SAUK

The Sauk County Medical Society met in September at St. Clare's Hospital, Baraboo. It was a Public Health meeting.

TRI-COUNTY

The Tri-County (Trempealeau, Jackson, Buffalo) Medical Society met in September at the Club Midway, Independence. *Dr. Joseph B. Durst*, La Crosse obstetrician, discussed the problem of premature delivery.

CORRECTION!

In the August issue, County Society Proceedings, page 23, there was an inadvertent error in the Brown county item. It should have read . . . "that the Brown County Welfare Council be the coordinating body and that the Brown County Medical Society (and not the Council) be represented on the coordinating body by a single physician. . . ."

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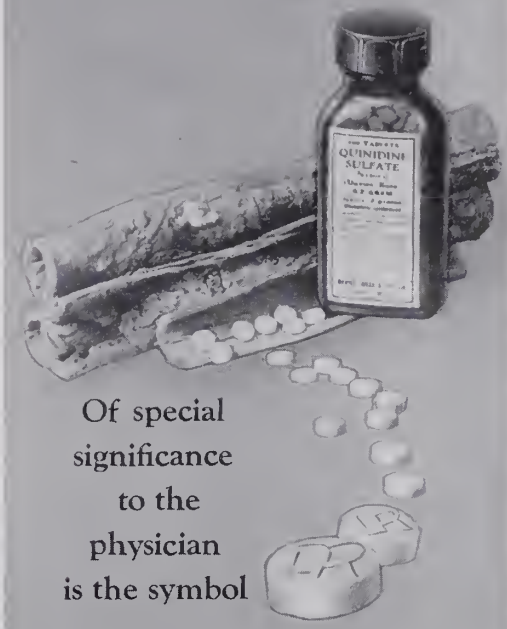

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SPECIALTY SOCIETY PROCEEDINGS

Wisconsin State Medical Assistants Society

Wisconsin Medical Assistants were well represented at the 7th National Convention of the American Association of Medical Assistants at the Eden Roc Hotel in Miami Beach, Florida, October 9–13. Miss Alice Budny, Milwaukee, president of AAMA, presided at the Miami meeting. Wisconsin Medical Assistants held a reception in honor of Miss Budny.

The convention combined intensive educational sessions and workshops designed to help members become more proficient on the job. Among the speakers who addressed the assembly was Dr. Edward R. Annis, president of the American Medical Association.

Miss Edith Murphy, Milwaukee, president of the Wisconsin State Medical Assistants Society, was honored at the Annual State Presidents Luncheon. The AAMA now has 35 affiliated state chapters, with 6 more states to be presented with charters at the Miami convention.

Dr. Daniel Dorchester, Sturgeon Bay, is a national advisor to the American Association of Medical Assistants and attended the meeting.

Wisconsin delegates were: Miss Edith Murphy, Milwaukee; Mrs. June Gillette, Sheboygan; and Mrs. Marie Swain, Beaver Dam. Alternates were: Miss Viola Wendt, West Bend; Mrs. Margaret Russell, Waukesha; and Mrs. Aleen Piepenburg, Waukesha.

Certification examinations for Medical Assistants were given prior to the convention, October 7–8, at the University of Miami.

Wisconsin Urological Society

The Wisconsin Urological Society held its thirty-sixth annual meeting on April 19–20, 1963, at Milwaukee. The following officers were elected for the coming year: president, *Dr. Anton P. Schoenenberger*, Madison; president-elect, *Dr. John J. Mueller*, Madison; and secretary-treasurer, *Dr. Sidney P. Hurwitz*, Milwaukee. The next annual meeting of the Society will be held in Madison, April 24–25, 1964.

Wis/Mich Ophthalmology and Otolaryngology

The Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology held a two-day meeting in September, at Bailey's Harbor. Dr. Morris Snitman, University of Illinois, Chicago, presented a talk on "Adequate versus Radical Management of Neoplastic Disease of the Head and Neck"; and the ophthalmologists of Green Bay presented a "Survey of Glaucoma in the Green Bay Area."

Wisconsin Society of Obstetrics and Gynecology

The 1963–1964 officers of the Wisconsin Society of Obstetrics and Gynecology are; president, *Dr. F. J. Stoddard*, Milwaukee; immediate past president, *Dr. Ben Peckham*, Madison; and secretary-treasurer, *Dr. Raymond E. Whitsitt*, Madison. The board of governors includes: *Dr. George Kilkenny*, Milwaukee; *Dr. Ralph Campbell*, Madison; and *Dr. D. O. Price*, Madison.

Milwaukee Oto-Ophthalmic Society

The new officers of the Milwaukee Oto-Ophthalmic Society for the 1963–1964 term are: *Dr. Ralph Teitgen*, president; *Dr. Arthur W. Tacke*, vice president; and *Dr. Herbert Giller*, secretary-treasurer. The program for the coming year will consist again of dinner meetings, with guest speakers from other communities, and the Milwaukee area.

Wisconsin Academy of General Practice

Dr. Wendell D. Hamlin of Mineral Point has been named president-elect of the Wisconsin Academy of General Practice. The academy also chose *Dr. Thomas Cox*, Glendale, secretary-treasurer; *Dr. Marvin Olson*, Schofield, speaker-elect of the academy's congress of delegates; and *Dr. Gerald Derus*, Madison, vice speaker-elect. The academy installed *Dr. Walton Manz* of Eau Claire as its new president, to succeed *Dr. Joseph Devitt*, Milwaukee. Doctor Hamlin and the other officers will assume their duties next year.

Dr. W. D. Hamlin

Wisconsin Society of Anesthesiologists

At the September 29 meeting of the Wisconsin Society of Anesthesiologists, officers were elected for next year. They are: president, *Dr. David Noll*, Verona; president-elect, *Dr. Sherman Myers*, Milwaukee; and secretary–treasurer, *Dr. Sheldon Burchman*, Milwaukee.

Wisconsin Surgical Society

The fall meeting of the Wisconsin Surgical Society was held in Manitowish Waters, September 13 and 14.

Dr. C. Morrison Schroeder, Milwaukee, presided over both afternoon programs. The first afternoon program featured a panel discussion on "Surgical

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Physicians whose names appear in italic are members of the State Medical Society.

Treatment of Polyps of the Colon," moderated by *Dr. Jack A. Killins*, Green Bay, and made up of panel members *Dr. Kenneth E. Lemmer*, Madison; *Dr. Richard H. Lillie*, Milwaukee; and Dr. Richard Varco, Professor of Surgery, University of Minnesota. Another panel discussion followed on "Treatment of Acute Cholecystitis: Surgery versus Conservative Management," with *Dr. Louis D. Graber*, Oshkosh, as moderator, and a panel consisting of *Dr. E. H. Ellison*, Milwaukee; *Dr. Norman Becker*, Fond du Lac; and Doctor Varco.

Other papers, which were presented by residents, included the following: "Effects of Excessive Hydrochloric Acid on the Canine Gastrointestinal Tract," by Dr. Peter Parker, Milwaukee County General Hospital; "Intra-arterial Infusion of 5-Fluorouracil in Treatment of Cancer," by Dr. William A. Kisken, University Hospitals, Madison; "Differentiation of Viable from Nonviable Intestine by Relative Impedance Measurement," by Dr. Larry C. Carey, Milwaukee County General Hospital; and "Influence of Infusion of Activated Pancreatic Secretions into Biliary Radicals of the Liver," by *Dr. John J. Foley*, Milwaukee County General Hospital.

During the evening program, Doctor Becker spoke on "Observations on Surgery and Allied Subjects in the Soviet Union."

Papers presented at the second afternoon program consisted of: "Treatment of Undisplaced Carpal Navicular Fractures When Diagnosis Has Been Delayed," by *Dr. George F. Pratt*, Rhinelander; "Ovarian Cysts and Tumors in Childhood," by *Dr. Donald S. Thatcher*, Milwaukee; "Postoperative Salt Retention: A Fallacy?," by *Dr. Joseph C. Darin*, who appeared by invitation, sponsored by *Dr. Walton D. Thomas*, Milwaukee; "Surgical Treatment of Pulmonary Embolism," by *Dr. Richard D. Sautter*, who also appeared by invitation, sponsored by *Dr. Ben R. Lawton*, Marshfield; and "Surgical Treatment of Common Duct Strictures," by Doctor Varco.

Also presented was the prize-winning resident paper, "Prevention of Infection in Experimental Wounds by Topical and Parenteral Agents," by *Dr. Rudolph P. Gingrass*, Veterans Administration Hospital, Wood.

American Cancer Society—Wisconsin Div.

The Annual Meeting of the Wisconsin Division, American Cancer Society, was held October 16–18 at the Park Motor Inn, Madison. Dr. Wendell G. Scott, president-elect, the American Cancer Society, gave the annual dinner address. Doctor Scott is a professor of Clinical Radiology, Washington University School of Medicine, St. Louis; and is also associate editor of the AMERICAN JOURNAL ROENTGENOLOGY, RADIUM THERAPY and NUCLEAR MEDICINE.

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William H. McCreary, Jr., M. D.
Adam Fueredi, M. D.
L. O. Mastalir, M. D.

NEWS OF WISCONSIN PHYSICIANS

ACOG Fellows

Dr. George J. Petersen, Appleton, has been chosen a fellow-elect in the American College of Obstetrics and Gynecology. Candidates for fellowship include *Dr. John R. Flanary*, Milwaukee, and *Dr. Henry M. Waldren, Jr.*, Milwaukee. Dr. David K. Criswell, Beloit, is a candidate for junior fellowship.

Dr. Angevine to Present Paper

Dr. Murray Angevine, University of Wisconsin Medical School, Madison, will present "Late Effects of Radiation in Relation to Cancer in Japan," at the 1963 Scientific Session of the American Cancer Society, New York City, Oct. 21–22. The conference will deal with unusual forms and aspects of cancer in man, and is sponsored by the New York Academy of Sciences, The American Cancer Society, and the National Cancer Institute.

Co-Editor of Book on Cardiopulmonary Diseases

Dr. Andrew L. Banyai, Chicago, clinical professor of medicine, emeritus, Marquette University, Milwaukee, is co-editor with Dr. Burgess L. Gordon, Jefferson Medical College, of a new book ADVANCES IN CARDIOPULMONARY DISEASES, Volume 1. The volume presents selected lectures from the 1961 Series of postgraduate courses presented by the Council on Postgraduate Medical Education of the American College of Chest Physicians.

Dr. Petajan is Assistant Professor

Dr. Jack H. Petajan, Madison, has taken up duties as an assistant professor in neurology and physiology, University of Wisconsin Medical School.

Assistant Professor in Pediatrics

Dr. Marc F. Hansen has been appointed assistant professor in pediatrics, University of Wisconsin Medical School. He received his M.D. degree from Harvard Medical School, and after interning at Boston City Hospital, he came to the University of Wisconsin Hospitals for a pediatric residency. He subsequently served in the Army, and then returned to Madison to spend the past two years at the Enzyme Institute with a joint appointment in the department of pediatrics.

Instructor in Gynecology and Obstetrics

Dr. Gloria E. Sarto has been appointed a part-time instructor in the department of gynecology and obstetrics, University of Wisconsin Medical School. She earned her M.D. degree at the University of Wisconsin, Madison, and interned at Cleveland Metropolitan General Hospital. Doctor Sarto then returned to University Hospitals for her residency in gynecology and obstetrics.

New Faculty Member

Dr. William A. Kisken has been appointed an instructor in the Department of Surgery, University of Wisconsin Medical School, Madison. Doctor Kisken earned his M.D. from the University of Chicago Medical School. He interned at Blodgett Memorial Hospital, Grand Rapids, Mich., and served his residency in surgery at the University of Minnesota Hospitals.

Elected to Medical Research Society

Acting Dean of the Medical School, University of Wisconsin, James F. Crow, Ph.D., and Dr. Harry Waisman, department of pediatrics, were recently elected to the Board of Directors of the Wisconsin Society of Medical Research.

Dr. Sievert to Head Rehabilitation Center

In charge of the rehabilitation activities in Madison General Hospital's new psychiatric-rehabilitation wing is *Dr. Robert A. Sievert*, Madison. Although Doctor Sievert already holds this position, he will be overseeing the rehabilitation program on weekends and by mail until July, 1964, when he completes a special, intensive two-year course at the Institute of Physical Medicine and Rehabilitation in New York City and passes Wisconsin State Medical Board specialty examinations. Doctor Sievert graduated from the University of Wisconsin Medical School in 1960, and, after serving his internship at Madison General, spent a year as a resident physician in internal medicine at La Crosse Lutheran Hospital.

General Practitioner Meetings

The general practitioner meetings held in June in Milwaukee and Wausau attracted 107 and 167 persons, respectively, *Dr. F. J. Hofmeister*, Wauwatosa, reported. Active in the planning of both meetings were *Dr. Joseph S. Devitt*, Milwaukee, then president of the Wisconsin Academy of General Practice; and *Dr. Alex Krembs*, Milwaukee, chairman of the Wisconsin Section of the American College of Obstetricians and Gynecologists.

Dr. Murray Joins Boren Clinic

Dr. Richard C. Murray has joined the staff of the Boren Clinic, Marinette, as obstetrician and gynecologist. He is a 1957 graduate of Marquette University School of Medicine and interned at Milwaukee Hospital, where he also completed a three-year residency in 1961. For the past two years he

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Physicians whose names appear in italic are members of the State Medical Society.

Wisconsin Heart Association Photo

Dr. William B. Hildebrand (center), Menasha, received a distinguished service plaque for his activities as a 1963 State Heart Fund chairman. *Dr. Raymond L. Rice* (right), Milwaukee, past-president of the Wisconsin Heart Association, who made the presentation, and *Dr. Charles W. Crumpton*, Madison, current WHA president, congratulated Doctor Hildebrand.

has been chief of the obstetrical-gynecological service at the U. S. Army Hospital, Fort Benjamin Harrison, Indianapolis, Ind.

Dr. Melms Joins Red Cedar Clinic

Dr. Frederick A. Melms has become associated with the Red Cedar Clinic, Menomonie. Doctor Melms is a 1959 graduate of the University of Wisconsin Medical School. He spent the past three years in Germany with the U. S. Air Force as a medical officer.

Dr. Scribner Goes to Syracuse

Dr. Lewis F. Scribner, Jr. is leaving the Monroe Clinic, Monroe, to join two other allergists in private practice in Syracuse, N. Y. Doctor Scribner has been in Monroe since 1961, also serving as a clinical instructor at the University of Wisconsin.

Dr. Cooper Opens Private Practice

Dr. Thomas H. Cooper, dermatologist, who has been practicing in Janesville since 1960, has opened a private practice. He was associated formerly with the Monroe Clinic and Janesville Medical Center. A native of Oregon City, Ore., Doctor Cooper received his M.D. from Marquette University School of Medicine. He took his internship at St. Joseph Hospital, Milwaukee, and specialty training at the Veterans Administration Center, Wood, Milwaukee County Hospital, and Milwaukee Children's Hospital. While associated with the Monroe Clinic, he participated in the preceptorship program at the University of Wisconsin Medical School.

Dr. Wear Speaks on Kidney Disease

Dr. John B. Wear of the department of urology at the University of Wisconsin Medical School, Madison, was the principal speaker at the monthly scientific meeting held in the Marshfield Clinic library recently. He discussed diagnosis of kidney disease with the use of radioactive mercury. Doctor Wear was introduced by *Dr. Nelson Moffat* of the Marshfield Clinic staff.

Dr. Conrad Joins Clinic, Hospital Staff

Dr. Arthur B. Conrad has joined the Gundersen Clinic and La Crosse Lutheran Hospital Department of Pathology as an associate to *Dr. Bernard Kalfayan*. Doctor Conrad, a native of Winona, Minn., received his M.D. in 1958 from the Marquette University School of Medicine, Milwaukee. He served his internship at Charles T. Miller Hospital, St. Paul, Minn. He completed his residency at South Bend Medical Foundation, South Bend, Ind., in June. He is a member of the American Society of Clinical Pathologists and the College of American Pathologists.

Dr. Terrano Reopens Practice

Dr. James V. Terrano reopened his practice in Plum City. It had been closed for several months. More than 1,000 residents of the area signed petitions asking restoration of service. Doctor Terrano came to Plum City in 1961.

Dr. Grindell Resigns Post

Dr. G. A. Grindell, resident physician at the Siren Memorial Hospital, Siren, for 17 years, has resigned. An appreciation dinner was held honoring the doctor for his long-term service.

Dr. Sciarra Attends Meeting

Dr. P. A. Sciarra, Sheboygan, attended the annual meeting of the Wisconsin Otolaryngological Society at Marshfield, in September.

Dr. Hoon Addresses Club

Dr. J. R. Hoon, Sheboygan, addressed the Evening Optimist Club, Sheboygan, recently. He spoke on the evaluation of cancer treatments.

Dr. Okagaki Discusses Cerebral Palsy

Dr. Henry Okagaki, orthopedic surgeon at University Hospitals, Madison, discussed cerebral palsy at the first meeting of the new year for the Junior Chamber of Commerce Auxiliary held in Madison.

Dr. Broderick is Guest Speaker

Dr. C. F. Broderick, Wisconsin Dells, was the guest speaker at a recent Rotary luncheon in Wisconsin Dells.

Wisconsin ACS Participants

The American College of Surgeons (ACS) will feature several Wisconsin physicians at its sectional meeting in New Orleans, March 16–19, 1964. *Dr. John D. Hurley,* Milwaukee, will speak on "Chemotherapy for Palliation"; *Dr. James V. Bolger, Jr.,* Waukesha, will contribute to a panel on "Surgery of Traumatic Cataract"; *Dr. George Nadeau,* Green Bay, will participate in a panel on "Surgery of Open-Angle Glaucoma"; *Dr. Manucher Javid,* Madison, will present a paper on the "Present Status of Urea in Neurosurgery"; *Dr. Bruce J. Brewer,* Milwaukee, will moderate a panel on "Acute Injuries to the Knee"; and *Dr. Frederick J. Hofmeister,* Milwaukee, will participate in a panel discussion of "The Progestogens."

ACOG New Fellows

The American College of Obstetricians and Gynecologists (ACOG) has released the names of new fellows from Wisconsin. They are: *Dr. Edwin H. Barnes,* Kenosha; *Dr. C. Robert Jackson,* Madison; *Drs. John J. Brady, William C. Fetherston, Howard Gass,* Milwaukee; *Dr. R. C. Wolfgram,* Oshkosh; and *Dr. Francis Gilbert,* Waukesha.

Dr. Cook Receives Fellowship

Dr. William A. Cook, Stevens Point, was awarded a fellowship from the American Thoracic Society, medical section of the National Tuberculosis Association, for study at the Medical College Hospital, Charleston, S. C. The fellowships are supported by Christmas Seal funds from the NTA and its affiliated associations.

Appointed to Committees

Dr. Murray Angevine, department of pathology, University of Wisconsin Medical School, Madison, has been appointed to the Committee on Systemic Disease of the National Research Council. Doctor Angevine will also serve on the American Registry of Pathology Committee of the American Society of Clinical Pathologists.

Attend Ophthalmology Meeting

Drs. *Peter A. Duehr, Frederick J. Davis, Matthew D. Davis,* and Guillermo de Venecia, Madison, attended the meeting of the Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology at Bailey's Harbor in September.

Attend Surgery Meeting

Drs. *Kenneth E. Lemmer*, *William Young*, William A. Kisken, and *Anthony Curreri*, Madison, attended the fall meeting of the Wisconsin Surgical Society in Manitowish Waters. Doctor Lemmer participated in a panel discussion on "Polyps of the Colon," and Doctor Kisken discussed "Intra-arterial Infusion of 5 FU in Treatment of Cancer."

SMS Section on Surgery

The new officers for the Section on Surgery of the State Medical Society are: chairman, *Dr. C. Morrison Schroeder*, Milwaukee; secretary, *Dr. John T. Mendenhall*, Madison; delegate, *Dr. Jack A. Killins*, Green Bay; and alternate, *Dr. Albert G. Martin*, Milwaukee.

Dr. Johnson Attends Meeting

Dr. Robert O. Johnson, department of surgery, University of Wisconsin Medical School, Madison, attended a phase one study meeting for the Clinical Drug Evaluation Program sponsored by the National Cancer Institute in Washington, D. C., in September.

Marquette–Jackson Clinic Postgraduate Meeting

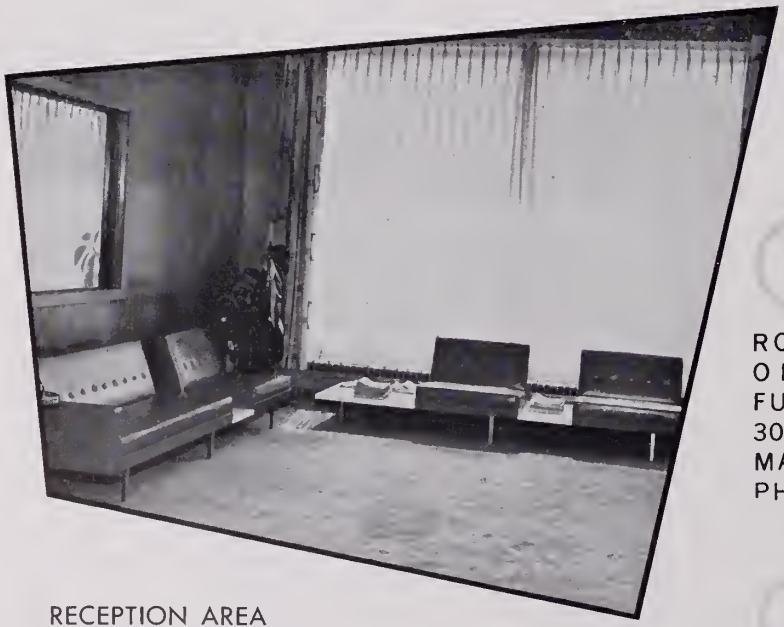
The Thirty-Third Annual Marquette–Jackson Clinic Postgraduate Meeting was held Wednesday, October 2, at the Park Motor Inn in Madison. Registration occurred at 1:30 p.m., and *Dr. Arnold S. Jackson*, Madison, gave the welcome at 2:00 p.m.

At 2:10 p.m., Dr. Louis Warrick, Jr., department of internal medicine, Jackson Clinic, Madison, presented a discussion on Problems and Complications of Insulin Therapy in Diabetes; and was followed by Management of Refractory Edema by Dr. William J. McAweeney, department of internal medicine, Jackson Clinic.

At 2:50 p.m., *Dr. D. William Hurst*, department of internal medicine, Jackson Clinic, spoke on Evaluation and Management of Pulmonary Emphysema; an intermission followed.

At 3:30 *Dr. Joseph C. Darin*, Assistant Professor of Surgery, Marquette University, Milwaukee, took up the subject of Primary Excision as a Method of Treatment for Thermal Injury; followed by *Dr. Leonard W. Worman*, Assistant Professor of Surgery, Marquette University, who spoke on Emergency Care vs. the Trauma Patient: The Role of the Emergency Hospital.

Carotid Arteriography and the Management of Head Injuries was discussed by Dr. Sanford J. Larson, chairman, department of neurosurgery, Marquette University, at 4:20 p.m. At 4:45 p.m. a panel



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discussion was presented on the Importance of Precise Diagnosis and Adequate Treatment in Urinary Tract Infections. Participants on the panel included: *Dr. John J. Mueller*, urology, *Dr. Barbara A. Brew*, obstetrics-gynecology, Doctor McAweeney, and *Dr. John H. Morledge*, internal medicine, Jackson Clinic. The panel was moderated by *Dr. William B. Parsons, Jr.*, Madison.

Dinner was served at 6:00 p.m., and *Dr. John S. Hirschboeck*, Dean of the Marquette University School of Medicine, presented a discussion on The Changing Picture in Medical Education.

Flight Surgeon of Year

Capt. *Lawrence J. Enders*, M.D., a graduate of Marquette University School of Medicine, Milwaukee, has been named flight surgeon of the year in the air defense command, U.S. Air Force. Captain Lawrence interned at St. Mary's Hospital, Milwaukee, in 1956–1957 and went into the air force where he took a three-year residency in aerospace medicine. In 1962 he was assigned to Otis Air Force Base in Massachusetts where he was awarded several honors. He is one of the 23 medical officers to be assigned to the national aerospace agency to work with the astronauts in both Projects Mercury and Gemini.

Dr. Booher to Retire

Dr. John Booher, Reedsburg, has announced his retirement.

Dr. Jensen Appointed to NYU Group

Dr. Frederick G. Jensen, Menasha, has been appointed to the Alumni Advisory Council on Admission at New York University, New York City. Doctor Jensen is president of the Jensen Clinic, Menasha. He received his M.D. degree from New York University College of Medicine in 1932. Members of the nationwide advisory council assist and advise the university admissions office, and help to further the university's admissions policies.

Dr. Samp Speaks on Health Fads

Dr. Robert J. Samp, Madison, spoke recently on health fads at the Wisconsin School Food Service Convention, Wisconsin State College, Stevens Point.

Dr. Starr Joins Garrison–Handy Clinic

Dr. Clifford H. Starr, Milwaukee, has joined the staff of the Garrison–Handy Clinic, Wisconsin Rapids. He will be associated with Drs. *Rogers E. Garrison, George H. Handy, Andrew W. Hulme*, and *Andrew M. Lucas* in general surgery. Doctor Starr received his M.D. degree from Marquette University School of Medicine in 1956, and interned at Misericordia Hospital, Milwaukee. He later was associated with *Dr. Dowe Cupery*, Markesan, and *Dr. Lorne Campbell*, Clear Lake, before returning to Milwaukee County Emergency Hospital and Milwaukee County Hospital for Mental Diseases. In June, 1963, he received an M.S. degree in surgery from Marquette University.

Dr. Carl Rogers to California

Carl R. Rogers, Ph.D., noted professor of psychiatry at the University of Wisconsin and a professor of the Wisconsin Psychiatric Institute, has announced his resignation from the university faculty for a California post. Doctor Rogers will become associated with the Western Behavioral Sciences Institute, La Jolla, Calif., where he will be a senior research scientist.

Dr. Simeon to Reedsburg

Dr. Rodolfo G. Simeon, Madison, has established an office in Reedsburg. Doctor Simeon is a graduate of St. Thomas University, Manila, Philippines. He interned at St. Bernard Hospital, Chicago, and spent a year of residency at MacNeil Memorial Hospital, Berwyn, Ill., and 4 years of residency at St. Francis Hospital, Evanston, Ill. Doctor Simeon was also on the staff of Kingston General Hospital, Kingston, Ontario, Canada, and, for the past 14 months has been at Jackson Clinic, Madison, where he was associated with *Dr. Arnold Jackson*.

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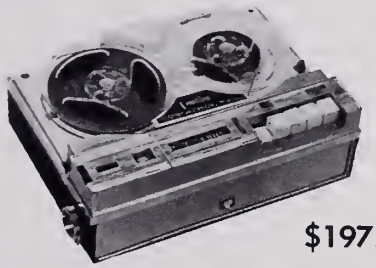

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Mental Health Hearings Scheduled in 22 Wisconsin Cities

THE STATE Mental Health Advisory Committee has arranged for 22 local hearings throughout Wisconsin in an effort to further the three mental health goals which are paramount in Wisconsin at this time according to Chairman H. Kent Tenney, M. D.: (1) needs of local communities must be recognized, (2) local communities must realize a need to plan for mental health, and (3) maximum use must be made of local and state existing personnel, programs, and facilities in mental health.

While the State Mental Health Advisory Committee is sponsoring the hearings, five public agencies, the Board of Health, Board of Vocational and Adult Education, Department of Public Instruction, Department of Public Welfare and the University of Wisconsin, along with three private agencies, the State Medical Society of Wisconsin, Wisconsin Council for Retarded Children, Inc., and Wisconsin Association for Mental Health, are cooperating in the effort.

The hearings, which started October 1 in Madison at the State Medical Society building, will be concluded on December 11.

Members of the Advisory Committee and state and private organization resource persons discuss mental health activities in education, health, welfare, rehabilitation, and research.

Specific topics covered include: (1) a review of legislation and legislative programs, (2) an introduction to the two-year federal grant planning now underway, (3) a quick glance at state and county institutions and organizational structure of the total mental health programs, including an illustrated explanation of how the various state departments and private organizations fit into this structure, and (4) a report by each agency involved in mental health activities on the services available through each.

To initiate information from the local level, statements and reports are available for each local area on community resources, the number of people affected by and the amount of dollars spent on mental illness. Local professional people are invited to give their assessment of local needs and a local committee reports on its findings of a personal survey of facilities, programs, and needs.

In addition to the exchange of information and the assessment of local needs, the local hearings stimulate and develop community interest and involvement in programs, provide a mutual meeting ground for interested citizens, professional people and legislators and provide a public record of the findings and results of each hearing.

Members of the hearing resource group are available for any private meetings or tours which may be developed by local committees and as time permits.

MENTAL HEALTH ADVISORY COMMITTEE

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Baraboo

The Committee is composed of seven citizen members, appointed by the Governor, and the chairmen of the Senate and Assembly Committees on Public Welfare.

It has the function of reviewing, evaluating and recommending state mental health programs and planning and the responsibility of coordinating these plans and programs.

It is the mental health public policy of Wisconsin to pursue knowledge of human behavior, broaden its scope and to make use of all that we know in order to achieve optimum fulfillment of human life. The Committee is dedicated to carrying out that public policy.

The Committee office is in Room 419 S. W., State Capitol, Madison, telephone 256-4411, extension 2815.

SCHEDULE OF LOCAL HEARINGS

No.	City	1963 Date	Counties	Chairman
1.	Madison	Oct. 1	Dane, Columbia, Sauk	Clifford Hutchinson
2.	Platteville	Oct. 3	Crawford, Grant, Iowa, LaFayette, Richland	Fr. L. J. Kieffer
3.	La Crosse	Oct. 4	La Crosse, Jackson, Monroe, Trempealeau, Vernon	Per Helliesen, M.D.
4.	Eau Claire	Oct. 22	Eau Claire, Dunn, Buffalo, Pierce, Pepin, St. Croix	Walter Conner
5.	Chippewa Falls	Oct. 23	Chippewa, Clark	Eugene Jackson
6.	Rice Lake	Oct. 24	Barron, Polk, Rusk, Burnett, Washburn, Sawyer	William L. Mason
7.	Waukesha	Oct. 29	Waukesha, Jefferson, Dodge	John Rowe
8.	Milwaukee	Oct. 30	Milwaukee	Mrs. Harold Holand
9.	Racine	Oct. 31	Racine	Mrs. Richard Chitko
10.	Superior	Nov. 5	Douglas, Bayfield	Kenneth Skelton
11.	Ashland	Nov. 6	Ashland, Iron, Vilas	Hon. Walter Cates
12.	Rhinelander	Nov. 7	Oneida, Price, Taylor, Lincoln	Rev. Calvin Fisher
13.	Appleton	Nov. 12	Outagamie, Calumet, Winnebago	Mrs. Kyle Ward, Jr.
14.	Green Bay	Nov. 13	Brown	Chas. A. Wunsch, M.D.
15.	Manitowoc	Nov. 14	Manitowoc, Door, Kewaunee	Mrs. Russell Wolfe
16.	Marinette	Nov. 19	Marinette, Florence, Forest, Langlade, Oconto	Mrs. Donald John
17.	Wausau	Nov. 20	Marathon, Shawano, Menominee	Geo. R. Andrews, M.D.
18.	Stevens Point	Nov. 21	Wood, Portage, Waupaca	Kirby Hendee
19.	Adams-Friendship	Dec. 3	Juneau, Adams, Waushara, Marquette, Green Lake	Gordon L. Sardeson
20.	Sheboygan	Dec. 4	Sheboygan, Fond du Lac, Washington, Ozaukee	Mrs. James Lohr
21.	Kenosha	Dec. 10	Kenosha, Walworth	Mrs. L. G. Merow
22.	Beloit	Dec. 11	Rock, Green	Frank Sutherland

1963 **Wisconsin**

Oct. 30-31 & Nov. 6: 1963 Clinical Advances and Review, Mount Sinai Hospital Staff, Milwaukee.

Nov. 7–9: Wisconsin Pharmacy Institute, Madison.

Nov. 14: UW/SMS "In Depth" Teaching Program on Neurology, S.M.I. Auditorium, 1300 University Avenue, and State Medical Society Building, Madison.

Nov. 19–20: Conference on Extension of Voluntary Health Insurance, sponsored by Wisconsin Physicians Service, at State Medical Society Headquarters, Madison.

Nov. 20–21: Third annual Milwaukee Medical Conference, at Milwaukee County Hospital, sponsored by the Medical Society of Milwaukee County.

Nov. 21: Eberbach Memorial lecture honoring Milwaukee Hospital centennial, by Dr. Carl E. Badgley, professor of orthopedic surgery, University of Michigan School of Medicine, Milwaukee.

Nov. 22: All-day symposium on Industrial Back Injuries, Mount Sinai Hospital, Milwaukee.

1964

Jan. 29: UW/SMS "In Depth" Teaching Program on Cardiology, S.M.I. Auditorium, 1300 University Avenue, and State Medical Society Building, Madison.

Feb. 20: UW/SMS "In Depth" Teaching Program on Orthopedics, S.M.I. Auditorium, 1300 University Avenue, and State Medical Society Building, Madison.

Feb. 24–29: Wisconsin Work Week of Health, State Medical Society Headquarters, Madison.

Mar. 19: UW/SMS "In Depth" Teaching Program on Endocrinology, S.M.I. Auditorium, 1300 University Avenue, and State Medical Society Building, Madison.

Apr. 2–3: Annual Meeting, Wisconsin Anti-Tuberculosis Association, Coach House Motor Inn, Milwaukee.

Apr. 4: Annual Meeting, Wisconsin Thoracic Society (WATA medical section), Coach House Motor Inn, Milwaukee.

May 11–13: Scientific program of Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

1963 **Out-of-State**

Oct. 30–Nov. 2: Twelfth Biennial Rocky Mountain Medical Conference, sponsored by seven Rocky Mountain state medical societies, at Las Vegas, Nev.

Nov. 2–3: National County Medical Societies Conference on Disaster Medical Care, Chicago.

Nov. 5–8: 16th Annual Meeting of the American Association of Blood Banks, Detroit, Michigan.

Nov. 5–13: Ninth Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Nov. 11–15: Course in Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Barbizon Plaza Hotel, New York City.

Nov. 13–Dec. 10: First Pan-Pacific Mobile Educational Lecture Seminar, New Zealand, Australia, Thailand, the Philippines, Hong Kong and Japan.

Nov. 15: Seventh Annual Symposium on Diabetes at the A. B. Dick Amphitheatre, Presbyterian-St. Luke's Hospital, Chicago, sponsored by the Diabetes Association of Greater Chicago.

Nov. 18–20: Scientific meeting of the Ophthalmology and Otolaryngology Section of the Southern Medical Association, New Orleans, La.

Nov. 18–21: Annual meeting of the Southern Medical Association, New Orleans, La.

Nov. 21–23: First Sectional Meeting (Midwest) of the American College of Physicians, Detroit, Mich.

Nov. 22–25: Annual convention, National Society for Crippled Children and Adults, Palmer House, Chicago.

Nov. 23: Annual meeting, American Rhinologic Society, Illinois Masonic Hospital, Chicago.

Dec. 1–4: Clinical Meeting, AMA, Portland, Ore.

Dec. 2–6: Course in Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Ambassador Hotel, Los Angeles.

MEDICAL MEETINGS

POSTGRADUATE COURSES

1964

Jan. 5–8: First Annual Postgraduate Seminar in Anesthesiology, Miami Beach, Fla., sponsored by the University of Miami and University of Florida schools of medicine.

Jan. 9–11: International Symposium on Anticoagulant Therapy in Ischemic Heart Disease sponsored by Miami Heart Institute at Fontainebleau Hotel, Miami Beach, Fla.

Jan. 12–18: Tenth Annual General Practice Review, University of Colorado School of Medicine, Denver.

Jan. 13–17: Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Hotel Fontainebleau, Miami Beach.

Feb. 2–8: Workshop in Teratology, University of Florida, Gainesville.

Feb. 7–8: Congress of the Professions, Lansing, Mich.

Feb. 17–19: Canadian-American Medical and Dental Ski Association meeting, Harbor Highlands, Harbor Springs, Mich. Sec-Treas: T. J. Trapasso, M.D., 816 Ashmun St., Sault Ste. Marie, Mich.

Mar. 16–19: American College of Surgeons, New Orleans, La.

June 15–19: Postgraduate course in psychiatry for internists, American College of Physicians, Psychiatric Institute and General Hospital, University of Maryland School of Medicine.

May 11–14: Annual scientific meeting, Aerospace Medical Association, Americana Hotel, Bal Harbour, Miami, Fla.

May 25–27: Annual meeting, American Thoracic Society, medical section of the National Tuberculosis Association, New York City.

June 15–19: Postgraduate course in Psychiatry for Internists, sponsored by the American College of Physicians, at Psychiatric Institute and the General Hospital of the University of Maryland School of Medicine.

Wisconsin Anti-Tuberculosis Association

The Wisconsin Anti-Tuberculosis Association's 1963 "Dearholt Days," originally scheduled for November 18 and 19, at Marquette University and the University of Wisconsin (Madison) respectively, have been postponed until sometime in January 1964.

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MEDICAL MEETINGS *continued*

10th Annual General Practice Review

The Tenth Annual General Practice Review, sponsored by the University of Colorado School of Medicine, will be held Jan. 12–18, 1964, in Denver, Colo. This is an annually presented postgraduate course designed especially for the general practitioner. Each day of the program will be devoted to a different area of practice: Sunday, obesity; Monday, medicine; Tuesday, pediatrics; Wednesday, surgery; Thursday, dermatology; Friday, obstetrics and gynecology; and Saturday, fluid and electrolytes. Registration may be for the entire course, or for any selected days. For further information and detailed program write to: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. Ninth Ave., Denver, Colo. 80220.

SMS/UW "In-Depth" Teaching Program

The second of five State Medical Society–University of Wisconsin Medical School teaching programs will be held on Neurology, Thursday, Nov. 14, in Madison. The first half of the program, the clinical portion on "Form and Function of the Nervous System" including Vascular Diseases, will be at the SMI Auditorium, 1300 University Avenue. It will be devoted to neurological examination, with a demonstration of a live model who will provide a means to illustrate some normal findings and some of the findings of a patient with a lesion of the nervous system. Also, one or two cases of cerebrovascular syndrome will be presented. The patients are chosen not only for the interest of their histories but also because of the findings they demonstrate. It is anticipated that the morning program will raise some questions which can be answered in considerable detail during the afternoon. *Dr. Hartwell G. Thompson, Jr.*, Associate Professor of Neurology, assumes responsibility for this examination.

The second portion of the program, from 12 n. to 4 p.m. will be held at the State Medical Society Building, 330 East Lakeside, Madison. A chartered bus will transport all attending persons from University Hospitals to the SMS building, where lunch will be served, and a program presented. Dr. Adolph L. Sahs, Professor and Chairman of the Department of Neurology, State University of Iowa College of Medicine, Iowa City, will discuss "Cerebrovascular Disease" (not including spontaneous subarachnoid hemorrhage). Following the formal presentation, there will be opportunity for questions and audience discussion. The second hour of the afternoon will be devoted to a series of brief presentations by members of the department of neurology and rehabilitation with comments by Doctor Sahs on management of spontaneous subarachnoid hemorrhage, management of cerebrovascular accidents caused by cerebral hemorrhage in hypertensive vascular disease, the proper use of long-term anticoagulant therapy in patients with cerebrovascular disease, and prospects for rehabilitation of the hemiplegic patient following a cerebral infarction.

The fee for the meeting, including lunch, is $5.00. Subsequent programs will be held on cardiology, Wednesday, Jan. 29; orthopedics, Thursday, Feb. 20; and endocrinology, Thursday, March 19. Application for reservation should be made to: Roy T. Ragatz, State Medical Society, Box 1109, Madison, Wis. 53701. Checks should be made out to the Charitable, Educational and Scientific (CES) Foundation.

American Association of Blood Banks

The 16th Annual Meeting of the American Association of Blood Banks will be held Nov. 5 to 8 at the Statler Hilton Hotel in Detroit, Mich. The dates are two days later than originally scheduled.

Dr. J. P. Soulier of Paris, Miss Margaret Polley of London, and Dr. Bruce Chown of Winnipeg, Canada, will be among those presenting scientific papers.

Convention chairmen are: scientific program, Dr. E. R. Jennings, Long Beach, Cal.; technical program, Dr. Julius Rutzky, Pontiac, Mich.; administrative program, Mrs. Dorothy C. Smith, R.N., Jacksonville, Fla; administrative and scientific ex-

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hibits, Dr. Herbert A. Perkins, San Francisco; and technical exhibits, Raymond F. Ambelang, Milwaukee, Wis.

The Association is an organization of community and hospital blood banks that collect, process and deliver more than half of the 5,500,000 units of blood used annually in the United States. It was organized in Dallas in 1947 under the leadership of blood banks that had cooperated that year in the Texas City disaster. It has members in every state and 25 foreign countries.

Workshop in Teratology

The need for deeper knowledge in experimental production of congenital deformities in laboratory animals has become obvious in recent years. Many scientists have recognized the need for study in this area, and the example of thalidomide has provided a further impetus. A major problem in this area is to determine the nature of normal and abnormal prenatal development, and to this purpose, a Workshop in Teratology will be offered February 2–8, 1964, at the University of Florida under auspices of the Commission on Drug Safety. The Workshop is made possible by an enabling grant from the Pharmaceutical Manufacturers Association.

The Workshop will familiarize scientists from government, industry and the universities with concepts and methodology used in studying congenital malformations. Breeding, dosage, evaluation of results, strain specificity in common laboratory animals, examination for deformities, clearing and related subjects will be considered, and the ease with which reliable information can be obtained will be emphasized.

Forty participants and a limited number of observers will be admitted from such fields as obstetrics, pediatrics, toxicology, pharmacology, biochemistry, endocrinology, pathology and others as determined by the admissions committee. Inquiries should be addressed to: D. C. Trexler, Executive Director, Commission on Drug Safety, 221 N. LaSalle St., Chicago 1, Ill.

Reunion and Pharmacy Institute

To mark the 80th anniversary of pharmacy instruction on the University of Wisconsin's Madison campus, the UW School of Pharmacy will welcome reunioning classes of alumni November 6. Special celebrations are planned for classes spanning the last half century of the school, those of 1913, 1918, 1923, 1928, 1933, 1938, 1943, 1948, 1953, and 1958.

Conducted tours of the newly remodeled research and teaching facilities will show returning alumni the growth of physical facilities, especially striking when compared with the school's first location on the first floor of South Hall in 1883. After the day-long open house, alumni and staff will gather at the Nakoma Country Club for a dinner-dance.

The annual Wisconsin Pharmacy Institute will be held in Madison Nov. 7–9.

Marquette Postgraduate Course

Marquette University School of Medicine in cooperation with The Milwaukee County General Hospital announces a postgraduate course in Pulmonary Diseases on November 14, 15, and 16. The meetings on the first two days will be from 9 a.m. to 5 p.m. and will be held in the Coffey Memorial Auditorium. The meeting on the last day will be from 9 a.m. to 12 noon in the King Conference room on the fifth floor.

Director of the course is Dr. William W. Stead, Professor of Medicine, at Marquette, and Clinical Director of Muirdale Sanitorium. Guest speaker will be Dr. Herbert O. Sieker, Professor of Medicine, Duke University School of Medicine, Durham, N. C. His appearance is supported by a grant from the Merck Sharp and Dohme Postgraduate Program.

Reservations should be made with: Joseph W. Rastetter, M.D., Director, Postgraduate Medical Education Programs, 8700 West Wisconsin Ave., Milwaukee, Wis. 53226.

ACP "Psychiatry for Internists"

A postgraduate course in psychiatry for internists has been added to the list of courses recently announced by the American College of Physicians. The course, number 19 on the ACP schedule, will be held June 15–19, 1964, at the Psychiatric Institute and the General Hospital of the University of Maryland School of Medicine.

One-half of the five-day session will be devoted to panel discussions of current concepts of personality development, psychopathology, psychiatric emergencies, and psychoneurosis and psychosomatic problems encountered in the practice of internal medicine. At other times, registrants will learn interviewing techniques and participate in patient interviews. Eighteen other courses will be presented under College sponsorship between September, 1963, and June, 1964.

Mount Sinai Hospital

The 1963 Clinical Advances and Review, presented by the staff of Mount Sinai Hospital, Milwaukee, will be held in the form of three morning meetings: Wednesday, Oct. 30, 8:30 a.m. to 1:00 p.m.; Thursday, Oct. 31, 9:00 a.m. to 1:00 p.m.; and Wednesday, Nov. 6, 9:00 a.m. to 1:00 p.m. A comprehensive course of interest to general practitioners will be presented. Subjects of current general interest in obstetrics and gynecology, radiology, pediatrics, surgery, internal medicine, dermatology, and orthopedics will be presented. The program is acceptable for 12 accredited hours by the AAGP. The registration fee is $25.00, and hotel reservations will be made upon request. All inquiries should be made to the Registrar, Mount Sinai Hospital, 948 N. 12th St., Milwaukee, Wis.

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BOOKS RECEIVED

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

MALPRACTICE LAW DISSECTED FOR QUICK GRASPING

By Charles L. Cusumano, member of New York Bar. Medicine-Law Press, Inc., 42 Broadway, New York 4, N. Y., 1962. 130 pages. Price: $10.00.

ATLAS OF VASCULAR SURGERY

By Falls B. Hershey, M.D., F.A.C.S., Associate Professor of Clinical Surgery, Washington University School of Medicine, St. Louis, Mo., and Carl H. Calman, M.D., F.A.C.S., Assistant in Clinical Surgery, Washington University School of Medicine, St. Louis, Mo. C. V. Mosby Co., St. Louis, Mo. 1963. 307 pages. Price: $18.00.

DIGESTIVE SYSTEM

Part II, Lower Digestive Tract, Volume 3 of the Ciba Collection of Medical Illustrations, by Frank H. Netter, M.D.; edited by Ernst Oppenheimer, M.D., Commissioned and published by CIBA. 1962. 243 pages. Price: $15.00.

PROTEIN METABOLISM

Influence of Growth Hormone, Anabolic Steroids, and Nutrition in Health and Disease; An International Symposium, Leyden, 25–26 June, 1962, sponsored by CIBA. Chairman, A. Querido, Leyden; edited by F. Gross, Basel. Springer Verlag, Berlin, Gottingen, Heidelberg. 1962. 521 pages.

A MANUAL OF SIMPLE BURIAL

By Ernest Morgan. The Celo Press, Burnsville, N. C. 1962. 64 pages. Price: $1.00.

TRANSPLANTATION

Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Margaret P. Cameron, M.A. Little, Brown and Co., Boston. 1962. 426 pages. Price: $12.00.

THE GROWTH OF MEDICAL THOUGHT

By Lester S. King, M.D. The University of Chicago Press, Chicago, Ill. 254 pages. Price: $5.50.

THE STORY OF BLOOD

By Kenneth Walker, M.A., M.B., B.Ch., F.R.C.S., F.I.C.S. Philosophical Library, New York, N. Y. 213 pages. Price: $6.00.

SYNOPSIS OF EAR, NOSE, AND THROAT DISEASES

By Robert E. Ryan, B.S., M.D., M.S. (ALR), F.A.C.S., William C. Thornell, A.B., B.M., M.D., M.S. (ALR), F.A.C.S., and Hans von Leden, M.D., F.A.C.S., F.I.C.S. 2nd edition. C. V. Mosby Co., St. Louis, Mo. 1963. 425 pages. Price: $7.50.

HANDBOOK OF THE PRACTICE OF ANESTHESIA

By John R. S. Shields, M.B., Ch.B., F.F.A.R.C.S., Associate Professor of Anesthesiology, Washington University School of Medicine, St. Louis, Mo. C. V. Mosby Co., St. Louis, Mo. 1963. 203 pages. Price: $6.85.

NEW AND NONOFFICIAL DRUGS

An annual compilation of available information on drugs, including their therapeutic, prophylactic and diagnostic status, as evaluated by the Council on Drugs of the American Medical Association. J. B. Lippincott Co., Philadelphia. 1963. 902 pages.

CURARE AND CURARE-LIKE AGENTS

Ciba Foundation Study Group No. 12. Edited by A.V.S. De Reuck, M.Sc., D.I.C., A.R.C.S. Little, Brown and Co., Boston. 1962. 103 pages. Price: $2.95.

MARGIN OF SAFETY

By John Rowan Wilson. Doubleday & Co., Inc., Garden City, N. Y., 1963. 258 pages. Price: $4.95.

AN INTRODUCTION TO THE SCIENCE OF HUMAN BEHAVIOR

By John I. Nurnberger, M.D., Professor and Chairman, Department of Psychiatry; Director, Institute of Psychiatric Research, Indiana University Medical Center; C. B. Ferster, Ph.D., Executive Director, Institute for Behavioral Research; Research Associate Professor, University of Maryland; and John Paul Brady, M.D., Assistant Professor, Department of Psychiatry; Research Psychiatrist, Institute of Psychiatric Research, Indiana University Medical Center. Appleton–Century–Crofts, New York, N. Y. 1963. 379 pages.

INTESTINAL BIOPSY

Ciba Foundation Study Group No. 14. Edited by G.E.W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Margaret P. Cameron, M.A. Little, Brown and Co., Boston. 1962. 120 pages. Price: $2.95.

RESISTANCE OF BACTERIA TO THE PENICILLINS

Ciba Foundation Study Group No. 13. Edited by A.V.S. de Reuck, M.Sc., D.I.C., A.R.C.S., and Margaret P. Cameron, M.A. Little, Brown and Co, Boston. 1962. 125 pages. Price: $2.95.

THE FAT BOY GOES POLY-UNSATURATED

By Elmer Wheeler. Doubleday and Co., Inc., Garden City, N. Y. 1963. 156 pages. Price: $3.50.

SYNOPSIS OF GENITOURINARY DISEASE

By Austin I. Dodson, Jr., M.D., Associate Clinical Professor of Urology, Medical College of Virginia, Richmond, Va., and J. Edward Hill, M.D., Assistant Clinical Professor of Urology, Medical College of Virginia, Richmond, Va. 7th edition. C. V. Mosby Co., St. Louis, Mo. 1962. 384 pages. Price: $7.75.

THE CONSUMERS UNION REPORT ON FAMILY PLANNING

By the Editors of Consumer Reports and Alan F. Guttmacher, M.D., Director of Obstetrics and Gynecology, Mt. Sinai Hospital, New York; Clinical Professor of Obstetrics and Gynecology, College of Physicians and Surgeons, Columbia University; and President-elect, Planned Parenthood Federation of America. Consumers Union of U. S., Inc., Mount Vernon, N. Y. 1962. 146 pages. Price: $1.75.

THE RISK TAKERS

By Hugh McLeave. Holt, Rinehart and Winston, Inc., New York, N. Y. 1963. 208 pages. Price: $4.50.

BOOKSHELF *continued*

WOUND BALLISTICS

Prepared and published under the direction of Lt. Gen. Leonard D. Heaton, The Surgeon General, United States Army; Editor-in-chief, Col. James Boyd Coates, Jr., M.C.; Editor for wound ballistics, Maj. James C. Beyer, M.C. Office of the Surgeon General, Department of the Army, Washington, D. C. 1962. 883 pages.

ACTIVITIES OF SURGICAL CONSULTANTS

Volume I. Prepared and published under the direction of Lt. Gen. Leonard D. Heaton, The Surgeon General, United States Army; Editor-in-chief, Col. John Boyd Coates, Jr., M.C.; Editor for Activities of Surgical consultants, B. Noland Carter, M.D.; Associate editor, Elizabeth M. McFetridge, M.A. Office of the Surgeon General, Department of the Army, Washington, D. C. 1962. 621 pages. Price: $6.50.

INTERNAL MEDICINE IN WORLD WAR II

Volume II. Infectious Diseases. Prepared and published under the direction of Lt. Gen. Leonard D. Heaton, The Surgeon General, United States Army; Editor-in-chief, Col. John Boyd Coates, Jr., M.C.; Editor for internal medicine, W. Paul Havens, Jr., M.D. Office of the Surgeon General, Department of the Army, Washington, D. C. 1963. 649 pages.

CROSSEN'S SYNOPSIS OF GYNECOLOGY

By Daniel Winston Beacham, M.D., Associate Professor of Clinical Obstetrics and Gynecology, and Woodard Davis Beacham, M.D., Professor of Clinical Obstetrics and Gynecology, Tulane University School of Medicine, New Orleans, La. C. V. Mosby Co., St. Louis, Mo. 1963. 371 pages. Price: $7.50.

SPECIFIC AND NON-SPECIFIC FACTORS IN PSYCHOPHARMACOLOGY

Proceedings of a Symposium held at the Third World Congress of Psychiatry, Montreal, Canada, June 4–10, 1961. Edited by Max Rinkel, M.D. Philosophical Library, New York, N. Y. 1963. 174 pages. Price: $3.75.

BOOK REVIEWS

TRAITOR WITHIN: OUR SUICIDE PROBLEM

By Edward Robb Ellis and George N. Allen. Doubleday & Co., Inc., Garden City, New York. 237 pages. Price: $3.95.

This is a very readable book on the suicide problem, more readable perhaps than the average medical publication. The authors are both journalists and staff reporters for the *New York World Telegram and Sun*. It is also a very scholarly book, even if in its format it does not resemble the usual professional style. There is an absence of precise references to other publications, journals, etc. that would help to find one's way through the maze of published material on the subject. However, the writers have devoted obviously many years of intensive study to the problem and present a complete summary of the work done in this field up to the last year or two. This book can be recommended as a general introduction to one of the major neglected fields in medicine.—CARL H. FELNER, M.D.

BASIC ANXIETY

A New Psycho-biological Concept. By Walter J. Garre, M.D., Chief of Psychiatry, Veterans Administration Hospital, San Francisco, Calif. Philosophical Library, Inc., New York, 1962. 123 pages. Price: $5.00.

As stated in the preface, this book is the personal introspective speculation of the author. There are no references and no data. The profound portions are not new; the new ones are not profound. The book is unnecessary; it is not recommended.—J. D. KABLER, M.D.

STERIC COURSE OF MICROBIOLOGICAL REACTIONS

Ciba Foundation Symposium. Edited by F. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Cecilia M. O'Connor, B.Sc. Little, Brown and Company, Boston. 115 pages.

This little book contains five papers given at a study group on stereochemical specificity which was sponsored by the Ciba Foundation. The papers treat the following topics: a historical review, hydrogen transfer by pyridine nucleotides, reactions of lactic acid, specificity of steroid dehydrogenases, and the microbial and enzymatic reduction of ketones. The authors are all known authorities on their subjects and each paper is concluded with a lively and extensive discussion.

This book is highly recommended for anyone interested in this rather specialized aspect of microbiology and stereochemistry.—S. G. KNIGHT, Ph.D.

THE HUMAN FRAME

Giovanna Lawford. Anchor Books, Doubleday & Company, New York. 1961. (First published 1952). 109 pages. Price: 95¢.

This paperback is a series of 39 plates composed of simplified outline drawings of the human skeleton with very brief and simple explanations of each. It may be useful to the layman who wants a nontechnical concept of the subject.—H. W. MOSSMAN, Ph.D.

EPIDEMIC!

Frank G. Slaughter. Doubleday & Company, Inc., New York 1961. 286 pages. Price $3.95.

The author of *Epidemic* has fancied a situation for 1965 that has enough reality to make an intensely interesting story. The place is New York City, mainly Manhattan Central Hospital and neighborhood. The time covers seven critical days in which an epidemic of the plague develops in Manhattan. The circumstances leading up to the epidemic and the accompanying crisis are cleverly written: the tramp steamer, with infectious personnel and rats, entering the port; the captain and the rats leaving the ship; the dock strike; the garbage haulers strike; the organized neighborhood gangs;

the philanthropist; and the Communist subversive activities.

Cooperative action by the hospital authorities, the mayor and police, and the use of modern public health measures attempt to contain the outbreak. Concentrated efforts under the leadership of a capable immunologist lead to success. Romance, surgery, subversive activities, and tenement district gangs all play a part in making the action move rapidly. Fiction—but well worth reading.—GERALD W. LAWTON, Ph.D.

SHOCK PATHOGENESIS AND THERAPY: AN INTERNATIONAL SYMPOSIUM

Stockholm, 27–30 June, 1961. Sponsored by Ciba.

This book is a stimulating one for those interested in research aspects of shock. The symposium depicts the wealth of data accumulated for experimental shock. The value of this data is unquestioned in contributing to basic understanding of the etiology and mechanism of various forms of shock in different animals. The book also illustrates again that our knowledge of shock is mainly from the laboratory. Not only are there large gaps in transferring this knowledge to clinical areas, but also there are marked differences between experimental and clinical shock. For example, "irreversible" hemorrhagic shock in the dog, an animal widely used experimentally, is accompanied by hemorrhagic necrosis of the bowel mucosa, but there is no clinical counterpart to this in the human. Dogs also may readily and predictably be bled to a state of irreversibility. On the other hand, according to J. M. Howard, page 193, hemorrhagic shock in a young man responds to transfusion and refractory shock is seldom a problem. In older people, however, transfusion after a period of shock may not always restore blood pressure and here the myocardium may be involved. There are various other experimental causes of death from shock, but clinical correlation is fragmentary. In one clinical study those dying without complications in shock were usually found, in fact, to have unrecognized and untreated blood loss.

More recent concepts of shock and renal failure associated with extra corporeal circulation and total body perfusion are discussed, as are new modalities of treatment of shock such as hypothermia. Drug therapy offers promise. While adrenal cortical steroids provide effective protection against endotoxic shock, vasoconstrictors commonly used in treating shock have not clearly been shown to increase survival. In contrast to this, drugs such as phenoxybenzamine (Dibenzyline) which blockade adrenergic vasoconstrictors are of value experimentally. It is suggested that controlled studies are necessary here as in many areas to show that these have a beneficial effect in patients.—HENRY BROWN, M.D.

PRACTICAL PEDIATRIC DERMATOLOGY

By Morris Leider, M.D., Associate Professor of Dermatology and Syphilology, New York University Post-Graduate Medical School, New York, N. Y.; Visiting Physician in Charge, Service of Dermatology, Bellevue Hospital, New York, N. Y.; Associate Attending Physician, University Hospital and New York University-Bellevue Medical Center, New York, N. Y.; Diplomate of the American Board of Dermatology and Syphilology. C. V. Mosby Co., St. Louis, Mo., 1961. 437 pages. Price: $13.75.

This is the second edition of this most useful and informative book. The title describes well the goal of the author, namely that the text be practical in nature. This is achieved, as brevity is maintained and numerous truly practical therapeutic suggestions are offered.

The style is particularly appealing, as for the most part the material is presented in an informal, personal, straight-forward manner.

The photographs, in black and white, are for the most part adequate, and many are excellent. Where a particular photograph does not truly represent a dermatosis, the author states so frankly.

Doctor Leider presents a rational and sensible, although iconoclastic, attitude toward the role of diet, skin tests, and psyche in atopic dermatitis. He states "psychic difficulties are more likely to be squential to atopic dermatitis rather than causal."

The formulary of "101 Useful Dermatologic Preparations" is valuable and its appearance on green-colored pages is a novel idea and makes reference to it quite simple. His concepts of therapy are modern, simple, and sensible.

The author happily is an etymological purist and the points he makes in this realm include the derivation of the lay term "shingles," and the meaning of the word "atopy." In addition, he mentions the correct plural of "glomus" and the proper usage of the words "fungus" and "fungous." For good measure he reminds us of the correct pronunciation of the word "bullae."

Although the book is not meant to be encyclopedic, at least mention of erythema neonatorum allergicum might have been made. His approach to the use of oral steroids in patients with atopic dermatitis does not, in the reviewer's opinion, present sufficient caution, and this could give rise to the injudicious use of steroids by those with less experience than the author in the handling of such problems. In addition, nothing is stated regarding the interdiction of vasodilating foods and beverages in acne rosacea.

It could be argued that certain entities discussed in the text are treated in cursory fashion, but in the interest of brevity, it is the author's privilege to do so.

Practical Pediatric Dermatology is a valuable piece of work and is highly recommended not only to the generalist and pediatrician, but to the dermatologist as well.—DONALD S. SCHUSTER, M.D.

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Alternates

C. J. Picard, Superior, 1964
George Collentine, Jr., Milwaukee, 1965

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	Wm. Smiles 522 W. 2nd St., Ashland	C. A. Crand 206–6th Ave., W., Ashland	
Barron–Washburn–Sawyer–Burnett	D. G. MacMillan Barron	J. K. Hoyer 40 W. Newton, Rice Lake	Second Tuesday 7:30 p.m.
Brown	John E. Dettman 519 S. Monroe Green Bay	Frank Urhan Rm. 308, City Hall, Creen Bay	Second Thursday°
Calumet	K. R. Humke Chilton	R. E. Knauf Chilton	
Chippewa	Charles A. Kemper 727 Maple, Chippewa Falls	C. T. Bowe Cadott	Second Tuesday
Clark	E. Dolf Pfefferkorn Colby	Bahri Cungor Loyal	
Columbia–Marquette–Adams	R. T. Cooney 310 W. Conant St., Portage	J. W. Pavelsek, Jr. 122½ E. Cook St., Portage	Every Third Month 7:00 p.m.
Crawford	M. S. Carrity 610 East Taylor St., Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	R. N. Allin 1313 Fish Hatchery Rd. Madison	Cordon Davenport 110 E. Main, Madison	Second Tuesday°°
Dodge	Fred A. Karsten 514 E. Lake St., Horicon	Norman Erickson 302 N. Spring St., Beaver Dam	Last Thursday°
Door–Kewaunee	Patricia Lanier Kewaunee	E. W. Wits 213 Ellis, Kewaunee	
Douglas	L. R. Rosin 2231 E. 5th St., Superior	Enzo Krahl 324 Board of Trade Bldg. Superior	First Wednesday° Hotel Superior
Eau Claire–Dunn–Pepin	R. R. Richards 605 Walker Ave., Eau Claire	W. H. Walter 131 S. Barstow St., Eau Claire	Last Monday
Fond du Lac	C. M. Flannagan 80 Shehoygan St. Fond du Lac	W C. Kendell 92 E. Division St., Fond du Lac	Fourth Thursday°
Forest	O. S. Tenley, Waheno	D. V. Moffet, Crandon	
Grant	C. L. Steidinger Platteville	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Creen	W. J. Fencil 921 16th Ave., Monroe	B. H. Brunkow 921 16th Ave., Monroe	
Green Lake–Waushara	Grant Stone 124 N. Wisconsin, Berlin	L. J. Seward 147 N. State St., Berlin	Last Thursday, every other month starting in Jan.

° Except June, July and August. °° Except July and August

List of Officers and Scheduled Meetings of County Medical Societies (Continued)

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	David Downs Dodgeville	E. J. Hohler Mineral Point	First Thursday following first Monday
Jefferson	E. A. Miller 133 Riverlawn Ave. Watertown	J. S. Garman 144 W. Madison, Waterloo	Third Thursday*
Juneau	J. H. Vedner Mauston	Jack Strong Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	J. J. Lutz 1202 60th St., Kenosha	G. F. Armstrong 6530 Sheridan Rd., Kenosha	First Thursday* Elks Club
La Crosse	George Skemp 312 State St., La Crosse	Ruth Dalton St. Francis Hosp., La Crosse	Third Monday
Lafayette	R. E. Hunter Argyle	L. L. Olson Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	Earl J. Roth 606 Superior, Antigo	First Monday
Lincoln	J. D. Millenbah 121 S. Mill St., Merrill	E. O. Ravn, Jr. 1802 9th St., Merrill	
Manitowoc	Charles E. Wall 904 South 8th St. Manitowoc	G. H. Stannard, Jr. Holy Family Hospital Manitowoc	Last Thursday
Marathon	R. H. Brodhead Box 838, Wausau	George Kordiyak 126 Grand Ave., Wausau	
Marinette–Florence	R. J. Maginn 1232 Mill St., Niagara	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	R. A. Frisch 425 E. Wisconsin Ave., Milwaukee	W. C. Curtis 10425 W. North Ave., Wauwatosa Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milw.	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	G. R. Sandgren Suring		
Oneida–Vilas	Allen Johnson Rhinelander	Marvin Wright 1020 Kabel Ave., Rhinelander	Monthly
Outagamie	F. M. Hauch 722 W. Lawrence St., Appleton	Wm. Chandler 402 W. Wisconsin, Appleton	Third Thursday* Elks Club
Ozaukee	R. F. Henkle 549 W. Grand Ave., Port Washington	P. W. Wallestad 502 W. Jefferson Port Washington	
Pierce–St. Croix	H. J. Laney Prescott	P. H. Gutzler River Falls	Third Tuesday
Polk	Donald Fink St. Croix Falls	Lloyd L. Olson St. Croix Falls	Third Thursday 7:00 p.m.
Portage	Walter Gramowski 319½ W. Main St. Stevens Point	Albert Kohn 313 N. Fremont Stevens Point	
Price–Taylor	J. D. Leahy Park Falls	J. L. Murphy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	W. H. Williamson 1101 Grand Ave., Racine	L. E. Jones 431 15th St., Racine Mr. G. N. Geraghty 600 Villa Street, Racine Exec. Sec.	Third Thursday
Richland	R. W. Edwards 118 West Mill St. Richland Center	L. M. Pippin 323 South Central Ave., Richland Center	First Thursday Richland Hospital
Rock	R. M. Baldwin 419 W. Pleasant St., Beloit	W. A. Scholten, Jr. 1146 Grant, Beloit	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	H. P. Baker Wonewoc	R. G. Knight 244 E. Main St., Reedsburg	Second Tuesday*
Shawano	H. F. Laufenberg Shawano	A. J. Sebesta 126½ S. Main St., Shawano	Third Wednesday
Sheboygan	Arthur C. Tompsett 920 Huron Ave., Sheboygan	J. F. Kovacic 708 St. Claire Ave., Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	Richard L. Holder 221 Main St., Black River Falls	J. H. Noble 1109 Harrison Black River Falls	Fourth Tuesday
Vernon	Roy B. Balder, Jr. Elroy	C. A. Ender Viroqua	Last Wednesday
Walworth	Henry Mol Elkhorn	Rocco S. Galgano 610 Walworth, Delavan	Second Thursday*
Washington	James Albrecht 118 E. Main St., Jackson	W. E. Scheunemann 626 Cedar St., West Bend	Fourth Thursday
Waukesha	Robert Feulner 630 Oxford Rd., Waukesha	W. E. Rosenkranz 720 N. Rochester, Mukwonago	First Wednesday
Waupaca	George Dernbach New London	Lloyd P. Maasch Weyauwega	
Winnebago	R. H. Quade 116 So. Commercial St., Neenah	E. J. Zmolek 302 N. Main St., Oshkosh	First Thursday
Wood	F. John Gouze 650 S. Central Ave., Marshfield	John W. Rupel 650 S. Central, Marshfield	Four times a year

* Except June, July and August.

Classified Advertisements

Advertisements in this section are accepted in two categories: PHYSICIANS' EXCHANGE and COMMERCIAL.

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PHYSICIANS' EXCHANGE: This section is limited to physicians and others desiring physician placement, sale of medical practice or equipment of a physician, sale or lease of medical buildings, etc. Advertisements from individual members of the State Medical Society of Wisconsin are accepted without charge. Widows of deceased member physicians are allowed to advertise without charge. The rates quoted above apply to ads placed by clinics and others. There is no additional charge for ads with Dept. numbers. For these ads, address replies to: Dept. ___, % Wisconsin Medical Journal, Box 1109, Madison 1, Wis. Advertisers using Dept. numbers forbid the disclosure of their identity. All inquiries are forwarded to them immediately.

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PHYSICIANS' EXCHANGE

FOR SALE: GENERAL PRACTICE in industrial city of approximately 50,000 in central Wisconsin. Fully staffed, fully manned 275-bed open staff hospital. Good recreational facilities. Should gross $35,000 the first year. Contact Dept. 64 in care of the Journal. m8tfn

FOR SALE: Established EENT practice, over 40 years in the heart of Milwaukee. Excellent referrals; will introduce; retiring. Contact Dept. 24 care of the Journal. m12tfn

FOR SALE: GENERAL PRACTICE. In beautiful northeastern Wisconsin where two doctors are covering potential of 10,000 people. Drastic need of a doctor, preferably two, to take over the practice of deceased physician. Office has large waiting room, two consultation rooms, examining room, two treatment rooms, laboratory, and library. A pharmacy is adjacent to the building. Equipment of the highest quality and TRAINED PERSONNEL ready to help you. Good hospital in town. Practice has great surgery potential. Townspeople will help you if you are the right person. Contact Mrs. H. A. Aageson, Oconto, Wis. Please supply references with your reply. m9–11

WANTED: GENERAL PRACTITIONER for association with two-man group located near Madison. Excellent hospital and recreational facilities. Salary open to start with partnership opportunity at end of one year. New building with excellent equipment and personnel. Contact Dept. 52 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER as associate. Immediately available opportunity to practice in well established group of two. Replacement for sudden loss of partner. Eventual partnership. 126 E. Main Street, Madison. AL 6–3171. m9tfn

WANTED: GENERAL PRACTITIONER as a replacement in town of 1,275 in southern Wisconsin. Gross receipts $42,000 in 1961, over $24,000 first 6 months 1962. Unopposed, good schools, churches, roads, fishing. Nearby accredited 200 bed hospital. Leaving for residency. Contact: D. L. Minter, M.D., Clinton, Wis. m9tfn

WANTED: PHYSICIAN with military service fulfilled to associate with a general surgeon also in general practice in northeastern Wisconsin in a city of 75,000. Excellent salary leading to early partnership. This is an A-1 financial opportunity. An early interview is appreciated. Contact Dept. 43 in care of the Journal. m4tfn

WANTED: INTERNIST, Board certified, to join two established surgeons. Excellent office facilities. Opposite 300-bed hospital—200-bed added expansion in progress. Town of 15,000. Central Wisconsin. Guaranteed salary. Percentage and partnership early prospects. Contact Paul F. Doege Medical Center, 512 St. Joseph Ave., Marshfield, Wis. m3tfm

OFFICE SPACE for two or three physicians, OB or two surgeons. To rent or to sell. Pharmacy in same building. Contact Dept. 33 in care of the Journal. m3tfn

GENERAL PRACTICE FOR SALE. Physician desiring own x-ray equipment may purchase radiographic, fluoroscopic and therapy equipment. Seven-room office on main corner in southern Wisconsin city of 35,000 occupied for over 40 years. Wish to retire. Reasonable price. Contact Dept. 19 in care of the Journal. m11tfn

PARTNER IN GENERAL PRACTICE WANTED in Green Lake county, town of 5,000. Fifty-bed private hospital Five grade schools and one high school. No predominant nationalities. Various churches. Main occupations are leather, fur and metal. Contact Dept. 20 in care of the Journal. m11tfn

STOPPED MEDICAL PRACTICE, ill health. For sale: Burdick EKG; high speed centrifuge, hematocrit centrifuge; steel office furniture, all new since 1957; office instruments; one repaired Hamilton table and cabinet; one new Hamilton cabinet; steel shelving etc.; and hydraulic table. John A. Booher, M.D., Reedsburg. m9tfn

EXCELLENT OPPORTUNITY for PSYCHIATRIST or physician interested in psychiatry to become associated with Mendota Hospital medical team. Permanent Civil Service position with associated benefits. Salary $1,000 and upward per month, depending upon experience and training. Housing available at nominal charge. Regular work hours. Staffed by about 30 psychiatrists and/or physicians. Investigate now. W. J. Urben, Superintendent, Mendota State Hospital, Madison 4, Wis. g9tfn

FOR RENT NOV. 1: Approximately 1,000 sq. ft. office space, ground floor, at 304 N.E. Avenue, Waukesha. Ward Evenson, D.D.S., 306 N.E. Avenue, Waukesha, phone LIberty 7–8000. 10tfn

WANTED: YOUNG GENERAL PRACTITIONER who is interested in general medicine and obstetrics to associate with a small group in northwestern Wisconsin. Salary arrangements to start with early partnership. Contact Dept. 70 in care of the Journal. 10tfn

FOR SALE: Good working older type x-ray machine with fluoroscopic attachment. Takes excellent bone pictures. Price $200. D. J. Sievers, M.D., 118 Spring St., Berlin, Wis. m10–12

WANTED: PHYSICIAN. Capable general practitioner preferred. Challenging assignment, affording opportunity to fully utilize talents and knowledge. Chance to enjoy normal life. Unusual fringe benefits. Contact Chief of Staff, Veterans Administration Center, Wood (Milwaukee), Wis. Telephone EVergreen 4–2000, Extension 250. 10–12

RESIDENCIES in Physical Medicine and Rehabilitation offer ideal opportunity in a growing field to the general practitioner who has decided to specialize. Comprehensive training utilizing Mayo Clinic facilities and faculty, at $3,600 to $8,000 stipend. Attractive community with excellent school system and cultural advantages. Contact E. C. Elkins, M.D., Mayo Foundation, Rochester, Minn. p10–12

URGENTLY NEEDED: Associate going for residency—another man urgently needed. Twelve miles $1,300 or more monthly. No investment. Available east of Fond du Lac, Catholic rural area. Start at June. Contact Jos. F. Miller, M.D., Mt. Calvary, Wis. m4tfn

WANTED: INTERNIST, Board certified or eligible for association with young internist in southeastern Wisconsin city of 90,000. Contact Dept. 980 in care of the Journal. m4tfn

FOR SALE: IN WISCONSIN. General practice, well established, same location 40 years, fully equipped 7-room office. Will take any reasonable offer and finance as you wish. Poor health forces retirement. Contact Dept. 912 in care of the Journal. m4tfn

WANTED: PHYSICIAN to share a clinic which is now occupied by an M.D. and a D.D.S., located in a prosperous southeastern Wisconsin industrial and farming community where the need for another physician is very great. Contact Dept. 827 in care of the Journal. 4tfn

FOR SALE: PEDIATRICS PRACTICE in suburb of large Wisconsin city; will introduce; buyer assume two-year lease; open hospital staff; physician leaving Sept. 1, 1962, for academic post. Contact Dept. 985 in care of the Journal. m5tfn

FOUR-ROOM SUITE plus use of large, pleasant waiting room available in air-conditioned, modern allergy clinic. ENT or medical man (GP?)-(Pediatrician?) would find space unusually advantageous. Adjacent Capitol Court Shopping Center, northwest Milwaukee area. Contact Dept. 67 in care of the Journal. m9tfn

OFFICE SPACE in medical clinic, 2218 North Third Street, Milwaukee, Wis.; Co. 4-2800. m3tfn

WANTED: GENERAL PRACTITIONER to replace physician who left for residency training. Fully equipped office available immediately. Town of 2,100 offers good hospital, skiing, hunting, golf, fishing and many other recreational advantages along the Chippewa River near its junction with the Mississippi. Financial remuneration should be excellent from the start. Contact Dept. 7 in care of the Journal. m9tfn

WANTED: GENERAL PRACTITIONER for associate with two other general practitioners in community of 2,400 with trade area of 7,000 in Green county. No investment required. Excellent clinical and diagnostic facilities. 200 bed hospital 15 miles. Good educational facilities. Convenient communications to recreational areas. Contact M. W. Stuessy, M.D., Brodhead. m3tfn

GENERAL PRACTICE available immediately in Milwaukee, Wis. (southeast side). Established 35 years, busy active practice, excellent location, beautiful ground floor clinic building, air-conditioned. Contact Dept. 41 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER. Must be graduate of class A medical school, preferably with two-year internship from class A teaching hospital. Midwest industrial city of 46,000. Open staffed, fully equipped, 250-bed hospital. Equal partnership if satisfactory within two years. Excellent recreational facilities. Have well established general practice. Contact Dept. 57 in care of the Journal. m5tfn

WANTED: OB-GYN physician and a general practitioner with some general surgical training to associate with another physician. Beautiful, large, new, well-equipped office. Parking lot. Air-conditioned. Starting salary $1,000. Partnership. City 10,000; drawing area 20,000. North Central Wisconsin. Contract Dept. 46 in care of the Journal. m4tfn

WANTED: GENERAL SURGEON, well qualified, to join two man clinic group in community of 40,000. Excellent facilities and limitless opportunity. State qualifications and availability when contacting Dept. 61 in care of the Journal. m7tfn

GENERAL SURGEON, Board certified, age 33, considers relocating; prefers solo practice but would consider group; am thinking of smaller community (20,000 or less) that will support surgical specialist. Contact Dept. 69 in care of the Journal. m9-10

WANTED: GENERAL PRACTITIONER as associate in a four-man group with adequate clinical facilities. Offer open for two or three year locum tenens or for permanent association in the group. Town of 4,000, well-equipped 80-bed hospital, in west central Wisconsin. Contact Dept. 10 in care of the Journal. m9tfn

GOOD LOCATION AVAILABLE for general practitioner. Nothing to buy. Will assist and refer all general practice cases. Contact C. A. Sholtes, M.D., Richland Center, Wis., Midway 7-2592 or 7-2544. m9tfn

FOR SALE: GENERAL PRACTICE, well trained and active, in new fully equipped clinic building. Present physician leaving for residency. Personnel well trained and efficient. Rural village 38 miles northeast of Madison. New school, swimming pool, good housing available. Subsidy can be arranged through village. Contact Joseph G. Brown, M. D., Cambria, Wisconsin. m6tfn

FOR SALE: GENERAL PRACTICE in Chippewa Falls, Wis.; well established, same location for 17 years, fully equipped 5½-room office. Will take any reasonable offer and finance as you wish. Office help available. Practice available because of recent death of William F. Janc, M.D. Contact Mrs. William F. Janc, 300 Macomber Street, Chippewa Falls, Wis. m7tfn

MEDICAL SUITE: Thiensville-Mequon Medical Center Building, Thiensville, Wisconsin. Two doctors' offices, four examining rooms, lead lined x-ray room, laboratory, general office and waiting room. Heating and air conditioning furnished by owner. Available Nov. 1, 1963. Phone Chestnut 2-1080 or Chestnut 2-2344. E. C. Neidner, 231 South Main Street, Thiensville, Wisconsin. 5tfn

EENT SPECIALIST NEEDED for Eau Claire and vicinity, population 60,000. Could take over 20-year practice of deceased physician. Very advantageous opportunity. Contact Mrs. S. B. Russell, 114½ Grand Avenue West, Eau Claire, Wis. m3tfn

GROUP OF THREE desires general practitioner as associate. New clinic building with adequate facilities, in town of 5,500. Recent graduate preferable. Contact Plymouth Clinic, Plymouth, Wis. m4tfn

LOCATION WANTED: Either general practice or radiology or combination. Board eligible in radiology and experienced GP. Will serve several small hospitals in radiology, or will purchase retiring physician's equipment. Contact Dept. 51 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER, immediate full partnership in active practice now grossing $50,000, all advantages of dual practice with vacation periods and free weekends. No investment required. Full hospital privileges. Contact Dept. 53 in care of the Journal. m4tfn

WANTED: A two man partnership would like a general practitioner interested in internal medicine or an internal medicine man to become associated. Location is in north central Wisconsin. New hospital facilities are available as well as a large extensively equipped office. Contact Dept. 59 in care of the Journal. m7tfn

GENERAL PRACTITIONER for psychiatric treatment center. Excellent working conditions. Starting pay from $12,000 to $15,600 based on experience and training. State Civil Service status with associated benefits. Forty-hour week, paid holidays; vacation, retirement fund. Some on grounds housing for single, or small families. Hospital location on beautiful 300-acre Lake Mendota frontage site. Contact Dr. W. J. Urben, Superintendent, Mendota State Hospital, Madison 4, Wis. g9tfn

FOR SALE: The following equipment has been used and is all in good working condition: Castle sterilizer, 4x6x16", on stand. Cameron electrical surgical unit and electrodes, on stand. Electric headlights, many vaginal speculi, all sizes. Any reasonable offer will be considered. E. G. Welke, M.D., 1310 Morrison, Madison, Wis. Telephone ALpine 6-7606. m10tfn

WANTED: GENERAL PRACTITIONER, serving township of 1,400 families, Kettle Moraine area, 25 miles north of Milwaukee, local fraternal organization will give assistance. New office building now in construction. Address inquiries to: Mr. La Vern Maschman, Chairman, Lions Committee, Colgate, Wis. p10

FOR SALE: Air-conditioned first floor office building, 1800 sq. ft., supplemental rental income from three dental offices upstairs. Owner in practice 13 years before leaving, had large, active practice. In city of Mayville, Wis., near Horicon marsh recreational area, state's largest cities for cultural, shopping activities. Open staff hospitals nearby. Contact Mr. Earl Anderson, 607 Seitz Ave., Mayville, Wis. m7tfn

FOR SALE: GENERAL PRACTICE in Prairie du Sac, Wis.; well established, same location for 15 years in fully equipped 4 room suite of offices, including small unit x-ray machine; ground floor clinic building, balance of space rented to dentist. Same office help for 15 years. Hospital facilities available in community, a rural village 27 miles northwest of Madison. New school, swimming pool and housing available. Office building and equipment may be purchased or rented. Practice available because of recent death of Milton Trautmann, M.D. Contact Mrs. Esther F. Trautmann, Prairie du Sac, Wis., or Attorney R. F. Curtin, Box 36, Sauk City, Wis. m9tfn

WANTED: PEDIATRICIAN for two-man department in 13-man multi-specialty group located in southern Wisconsin city of 37,000. Salary first two years, then share in profit. Excellent retirement and vacation policy. Contact Dept. 58 in care of the Journal. 6–11

WANTED: GENERAL PRACTITIONER or man with specialty who will do general practice and associate with one or two other men in well established practice. Fox River Valley. Immediate opening. Community of 50,000. Salary two years, then partnership. Contact Dept. 38 in care of the Journal. m4–5

WANTED: OPHTHALMOLOGIST for newly organized group in the Fox River Valley of Wisconsin. Community of over 50,000. Excellent living conditions, noted recreational area and above average opportunity. Salary two years then partnership. Contact Dept. 45 in care of the Journal. 4tfn

WANTED: GENERAL PRACTITIONER to join general practitioner in well established practice in southeastern Wisconsin. Town of 8,000. Class A accredited hospital. Salary or partnership if mutually agreeable. Contact Dept. 39 in care of the Journal. m3–5

URGENTLY NEEDED: General Practitioner to become associated with small clinic group in Milwaukee. Wis., preferably one who has had practical experience and a special interest in obstetrics or industrial surgery. First year, salary; then profit percentage leading to partnership. Contact Dept. 48 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER to replace retired physician in established three-man group. Must be interested in general medicine, obstetrics, and willing to assist in surgery. Fully equipped medical suite including x-ray and laboratory in town of 50,000 in Fox River Valley of Wisconsin. Unusual opportunity with eventual partnership. Contact Dept. 36 in care of the Journal. m3tfn

PHYSICIAN WANTED: General practitioner in northeastern Wisconsin wants part time help. Can use one man or combination to cover practice for week, month, or up to a year. Money no object for right man. No OB or surgery unless desired. Living facilities and car available. Contact Dept. 29 in care of the Journal. m1tfn

PLAN FOR PSYCHIATRIC residency for July, 1964? NIMH General Practitioner program: $12,000 yearly, partially tax free. Three-year approved, balanced didactic and clinical training. In Michigan's Vacationland. Dr. Curtis W. Page, Training Director, Traverse City State Hospital, Traverse City, Michigan. 6–10

FOR SALE: Genophthalmic chair, Genophthalmic refractor, Claison projector, eye glass display cabinet, treatment table, records from eye, ear, nose and throat practice—42 years. Price very reasonable. J. J. Sharpe, M.D., 150 E. First St., Fond du Lac; telephone 291 and 349. m3tfn

WANTED: PHYSICIAN to associate with two established general practitioners in southeastern Wisconsin industrial, agricultural community of 6,000. Prefer one who has had special surgical or obstetrical training and willing to do general practice along with surgery or obstetrics. Contact Dept. 31 in care of the Journal. m1–3tfn

HELP! Two-man practice with only one man! General practitioner. Small town. Salary first year; partnership later. T. S. Westcott, M.D., 115 West Chestnut St., Pardeeville, Wis. m3tfn

GENERAL PRACTITIONER or internist to take over a thriving established practice in new northwest side of Milwaukee. Plan to specialize in one to two years. Office large enough for two physicians with x-ray and laboratory facilities. Willing to turn over entire practice. Equipment can be purchased at cost. Contact Dept. 65 in care of the Journal. m9tfn

INTERNIST WANTED for established group in Milwaukee suburb. One year salary then progression to equal ownership. Busy practice, good hospital, and office facilities. Fine opportunity. Contact Dept. 66 in care of the Journal. 9–11

FOR SALE: Microscope (E. Leitz Wetzlar Germany), Stryker cast cutter, medical instruments, Renwal sterilizer, Baumanometer (Kompak model), Detecto doctor scale, Tonsilectome and tips, Bard Parker utility syringe outfit, stethoscope (triple change), Kidde dry ice apparatus. Mrs. Cecile Arnoldussen, 1618 S. Willkie St., Appleton, Wis. m9tfn

VIRGINIA, MINNESOTA. Pop. 14,000, area pop. 80,000. St. Louis County. OB–GYN specialist wanted on partnership basis with 20 others. Excellent hospital. Office space available in modern clinic with complete laboratory and x-ray service. Living space available in new, modern houses or apartment. Main sources of income in area are farming, taconite, and mining. All churches represented and excellent school. Social activities available, hunting and fishing. Contact Donald L. Werner, M.D., East Range Clinic, Virginia, Minn. 9tfn

WANTED: GENERAL PRACTITIONER to become associated with small group in central Wisconsin, preferably one who has had some practical experience, and has a special interest in obstetrics; also willing to only assist in surgery. Contact Dept. 969 in care of the Journal. m2tfn

ASSOCIATE WANTED in general practice. $18,000 guaranteed clear per year. Should earn $30,000 clear after two years. Contact Jos. F. Miller, M.D., Mt. Calvary, Wis. m7tfn

FOR SALE: Equipment of retiring physician, including National cautery; two Hamilton steeltone examination room suites—one buff, one white; Birtcher crystal bandmaster diathermy, with surgical attachments; accessories; various small instruments and treatment room supplies. Contact Mr. Harvey Schellpfeffer, 44 N. Main St., Mayville, Wis. m7tfn

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INTERVIEWS

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ALLERGIST WANTED to share offices with dermatologist. Located in thriving area, south central Wisconsin. Unusual opportunity. Applicant must be board certified or qualified and intending to become certified. Reply, with details of personal and professional qualities and qualifications, to Dept. 5 in care of the Journal. m8tfn

FOR RENT: OFFICE SPACE, 1200 sq. ft., for medical offices in modern, air-conditioned building at 16 East Gorham Street, Madison. Available for immediate occupancy. Will accommodate one or two physicians, preferably internists. Off-street parking. Contact Robin Allin, M.D., 1313 Fish Hatchery Road, Madison, Wis., phone ALpine 6–5521; or residence CEdar 3–2082. m8tfn

PHYSICIANS, with or without pediatric training, needed in maternal and child health program at salaries ranging from $9,960.00 to $13,200.00. Five-day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, Milwaukee Health Department, Municipal Building, Milwaukee 2, Wis. g8tfn

WANTED: OPHTHALMOLOGIST to rent or buy an office building. Write for full particulars to: E. A. Miller, M.D., 80 N. Main St., Clintonville, Wis. g8tfn

WANTED: MEDICAL DIRECTOR for institution for the retarded. Specialty in pediatrics or internal medicine required. Staff of five physicians plus consultants in all specialties. Salary $18,672 to $21,672 depending on qualifications. Write: Mr. John M. Garstecki, Superintendent, Southern Colony and Training School, Union Grove, Wisconsin. g8tfn

INDEX TO ADVERTISERS

Ames Company, Inc. — 71

Barr X-ray Co. — 32
Beecher's Records & Stereo — 45
Benson Optical Co. — 4
Borden's — 48
Burroughs Wellcome & Co., Inc. — 14, 57

California State Personnel — 67
Chatham Pharmaceuticals, Inc. — 19
Chicago Medical Society — 70
Ciba — 12, 13
Coca Cola Company, The — 40

Davies, Rose & Company, Ltd. — 33

Endo Laboratories — 64

Geigy Pharmaceuticals — 27, 28, 29, 30

Haug Drug Company — 16, 40
Hotel Schroeder — 40
House of Bidwell, Inc. — 32
Hurley X-ray Company — 48

Keeley Institute, The — 33

Lederle Laboratories — 9, 56
Lilly and Company, Eli — Front Cover, 20

Medical Protective Company, The — 18
Milwaukee Sanitarium Foundation — 48

Parke, Davis & Company — 2, 3
Physicians' Exchange — 67, 68, 69, 70

Rennebohm's — 48
Robins Co., Inc., A. H. — 37, 38, 39, 47
Roche Laboratories — Back Cover
Rogers Memorial Hospital — 18
Rorer, Inc., William H. — 26
Rowley & Schlimgen — 44

Sacred Heart Sanitarium — 36
St. Croixdale Sanatarium — 4
St. Mary's Hill Hospital — 43
Sanborn Company — 23
Saunders Company, W. B. — 7
Schering Corp. — 17
Searle & Co., G. D. — 21
Shorewood Sanitarium — 32
Smith Kline & French Laboratories — 15
Spence–McCord — 52

Time Insurance Company — 32

Wallace Laboratories — 6, 10, 11, 19, 49, 54, 55, 63
Winthrop Laboratories — 8, 22, 34, 58
Wisconsin Physicians Service — 62

the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

CONTENTS

Vol. 62, No. 11 NOVEMBER 1963

SCIENTIFIC ARTICLES

Co-Existent Cystosarcoma Phyllodes and Scirrhous Adenocarcinoma of the Breast, by W. G. Richards, M. D. and R. W. Way, M. D., Beaver Dam ---- 425

Chlorpropamide in Treatment of Multiple Sclerosis, by G. F. Tegtmeyer, Jr., M. D., Madison ---- 429

Emphysema of the Face Following Bowel Resection, by V. S. Falk, M. D., F. A. C. S., Edgerton ---- 431

Leiomyoma of the Fallopian Tubes, by A. H. Lipton, M. D., Milwaukee ---- 433

Clinicopathologic Conference, by Pearse Meighan, M.D., Appleton ---- 436

SPECIAL ARTICLES

Comments on Treatment: Antithyroid Drugs, by Deane N. Calvert, Ph.D., Milwaukee ---- 440

Eulogy to a Small Town Country Doctor, by Rose Ann Murphy, Lansing, Iowa ---- 446

Interim Session, House of Delegates, Oct. 18–19, Madison ---- 448

Transactions of 1963 Regular Session, House of Delegates, May 6–8, Milwaukee ---- 451

EDITORIALS

President's Page: Hospital Relations . . . Medical Education, by W. J. Egan, M.D., Milwaukee ---- 442

Kerr–Mills Challenge ---- 444

Remember the Good ---- 445

REGULAR FEATURES

County Society Proceedings ---- 31

Specialty Society Proceedings ---- 33

News of Wisconsin Physicians ---- 39

Society Records ---- 49

Medical Meetings ---- 53

Physicians' Exchange ---- 59

Index to Advertisers ---- 62

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ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 303 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.

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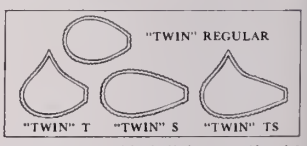

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DANE

Election of officers was held at the annual meeting of the Dane County Medical Society, Madison, October 8. They are: president-elect, *Dr. R. A. Straughn*, vice-president, *Dr. K. L. Siebecker*, Madison; and secretary-treasurer, *Dr. Gordon Davenport*, Madison. *Dr. Palmer R. Kundert*, Madison, assumed the office of president after serving for one year as president-elect.

Delegates chosen were: *Dr. H. M. Suckle*, Madison; *Dr. W. T. Russell*, Sun Prairie; Doctor Straughn; and *Dr. A. P. Schoenenberger*, Madison. Alternates are: *Dr. P. G. Piper*, Madison; *Dr. G. J. Derus*, Madison; *Dr. G. E. Oosterhous*, Madison; and *Dr. C. K. Kincaid*, Madison.

Members of the nominating committee were: *Dr. O. S. Orth*, chairman, Doctor Derus, *Dr. L. E. Holmgren*, *Dr. R. P. Sinaiko*, and Doctor Suckle, all of Madison.

New members are as follows:

Dr. Robert F. Korbitz was born at Eagle, Neb. and graduated from the University of Wisconsin Medical School in 1962. He completed his internship at St. Luke's Methodist Hospital, Cedar Rapids, Ia., and currently is in general practice in Madison.

Dr. George T. Bryan was born at Antigo, and graduated from the University of Wisconsin Medical School in 1957. He served his internship at North Carolina Baptist Hospital, Winston-Salem, N.C. He completed his residency in oncology receiving the degree of Ph.D. at the University of Wisconsin. Doctor Bryan is an assistant professor of surgery and clinical oncology at the University of Wisconsin Medical School.

Dr. Lou A. Raymond was born at Chippewa Falls and received his degree from the University of Wisconsin Medical School in 1962. He served his internship at Madison General Hospital and currently is in general practice in Sun Prairie, Wisconsin.

Dr. Paul J. Radlet was born at Green Bay and graduated from the University of Wisconsin Medical School in 1955. He served his internship at Milwaukee Hospital, Milwaukee, and completed his residency in otolaryngology at University Hospitals, Madison. Doctor Radlet is in private practice in Madison.

PIERCE-ST. CROIX

The Pierce-St. Croix County Medical Society held a meeting at the River Falls Medical Clinic, River Falls, in October. Dr. Samuel Hunter was the speaker.

RACINE

The regular business meeting and dinner of the Racine County Medical Society was held October 17 at The Breakers, Racine. John J. Batenburg, of Racine, spoke on the industrial development program in Racine.

Physicians whose names appear in italic are members of the State Medical Society.

COUNTY SOCIETY PROCEEDINGS

TRI-COUNTY

The Tri-County (Trempealeau–Jackson–Buffalo) Medical Society met October 22 at the Castle Hill Supper Club near Black River Falls. *Dr. Paul W. Phillips*, La Crosse, was the guest speaker.

SAUK

The Sauk County Medical Society met October 8 at The Ritz in Baraboo. *Dr. John R. Talbot*, Madison, spoke on "Therapy for the Seriously Ill Asthmatic Patient."

RICHLAND

The Richland County Medical Society met in Richland Center, Richland Hospital Library on October 3. *Dr. Francis M. Forster*, chairman of the Department of Neurology, University Hospitals, Madison, spoke on epilepsy. *Dr. James J. Tydrick*, Richland Center, became a new member of the society.

WINNEBAGO

The September meeting of the Winnebago County Medical Society was held at the Menasha Hotel, Menasha. It began with a social hour followed by dinner, and Robert Murphy, legal counsel for the State Medical Society, served as guest speaker. *Dr. Allan E. Talbot*, Neenah, was program chairman.

The Winnebago County Medical Society met at the Oshkosh Country Club October 3. Guest speaker was *Dr. John D. Hurley*, Milwaukee, who spoke on the use of cancer chemotherapy in general practice. The program chairman for the event was *Dr. Louis D. Graber*, Oshkosh.

WOOD

The Wood County Medical Society met in Marshfield in September, with an attendance of 51 persons. The Society decided to initiate a county-wide program of oral polio vaccination using Sabin oral vaccine Types I and II. It is anticipated that the program will be carried out in cooperation with the Wisconsin Jaycees. *Dr. George L. River*, Marshfield, presented a paper on myeloproliferative syndrome.

A new member of the Wood County Medical Society is *Dr. David Shapiro*, Wisconsin Rapids, a transfer from Outagamie County Medical Society.

The next meeting will be held Thursday, December 5.

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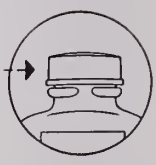

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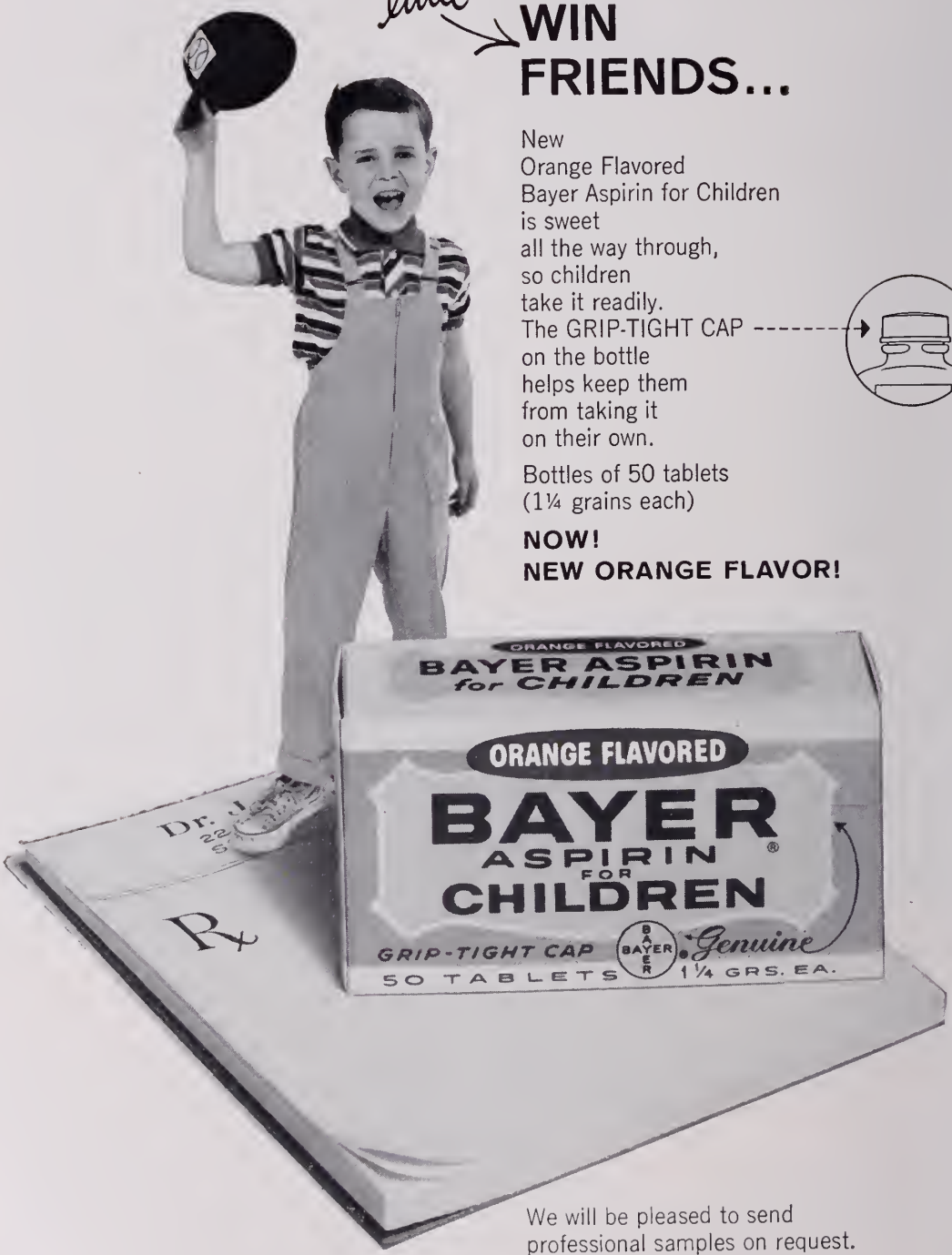

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SPECIALTY SOCIETY PROCEEDINGS

Wisconsin Society of Pathologists—Wisconsin Association of MTS

The Third Joint Meeting of the Wisconsin Society of Pathologists and Wisconsin Association of Medical Technologists was held in October at the Plankinton House, Milwaukee.

Following preconvention seminars, board of directors and business meetings on the first day, papers were presented on ensuing days. These included: "Proprietary Schools of Laboratory Personnel," by *Dr. David J. LaFond*, Milwaukee; "Incidence of Antibodies in Reported Transfusion Reactions," by *Dr. Byron Myhre*, Milwaukee; "The Current Status of the Certified Laboratory Assistants Program," by *Dr. Robert S. Haukohl*, Milwaukee; "A Rapid Method of Fluorescent Antibody Identification of Microorganisms," by Kenneth J. Smith, M.S., M.T. (ASCP), Milwaukee; "A Workable Control for Hemoglobin Determinations," Dr. Roland E. Berry, Iron Mountain, Mich.; "Frozen Pooled Serum as Controls for Blood Chemistry," by Doctor Berry; "Upper Respiratory Tract and Ear," by Dr. J. Daniel Wilkes, Bethesda, Md.; "New Trends in Medical Technology Teaching," by Merian B. Smith, M.T. (ASCP), Madison; "Urinary L.D.H.," by N. Baier, M.T. (ASCP), Beaver Dam; and "Two Tube Crossmatch," by Mary K. Stuiber, M.T. (ASCP), Madison.

Other papers were: "Some Effects of Antibiotics on the Bactericidal Activity of Serum," by Imogene Brown, M.S., M.T. (ASCP), Milwaukee; "Automated Amyloclastic Analysis of Serum Amalyse Activity," and "A Critique of Substrates, Controls and Techniques in the Amyloclastic Analysis of Serum Amalyse Activity," by Thomas Elmore, B.S., M.T. (ASCP), Milwaukee; "An Automated System for the Determination of Enzymes," by G. Phillip Hicks, Ph.D., Madison; "Serum Macroglobulins," by Margaret Kaser, Ph.D., Wood; "Bacterial and Viral Meningitides in Children," by *Dr. Samuel R. McCreadie*, Milwaukee; "Laboratory Procedures in the Isolation, Identification and Differentiation of Mycobacteria," by Paul G. McGuire, Jr., M.S., M.T. (ASCP), Winnebago; and "Establishing Normal Values from Daily Laboratory Results," by Doctor Berry.

At the meeting, the following officers were elected for the 1964 term: president, *Dr. Robert S. Haukohl*, Milwaukee; vice-president, *Dr. Philip G. Piper*, Madison; secretary and ASCP councilor, *Dr. David J. La Fond*, Milwaukee; treasurer, *Dr. Chesley P. Erwin*, Milwaukee; board of censors, *Dr. Joseph M. Lubitz*, Milwaukee, *Dr. James L. Jaeck*, Sheboygan, and *Dr. James W. Erchul*, Appleton; delegate to SMS, *Dr. Joseph L. Teresi*, Milwaukee; alternate, *Dr. Lars W. Kleppe*, Beloit; senior assemblyman to Congress of American Pathologists, *Dr. Norbert Enzer*, Milwaukee; and junior assemblyman to CAP, *Dr. Paul C. Dietz*, La Crosse.

Physicians whose names appear in italic are members of the State Medical Society.

ACOG Midwest Meeting

The American College of Obstetricians and Gynecologists (ACOG) sponsored two Midwest meetings recently. The Conference on Obstetric, Gynecologic, and Neonatal Nursing was held October 17–19 at the Pick-Congress Hotel, Chicago. The doctors' meeting was held in Milwaukee, November 21–23, at the Hotel Schroeder. The first day featured a program for Junior Fellows, younger doctors who have not yet completed all training necessary for full fellowship. Program chairman for this meeting was *Dr. William V. Luetke*, Madison.

Wisconsin State Medical Golf Association

The Annual Meeting and Golf Tournament of the Wisconsin State Medical Golf Association was held at the Branch River Country Club, Manitowoc County, in August.

Dr. William C. Harris, Racine, won the Presidents Trophy for first low gross with a score of 74. Second low gross was awarded to *Dr. Eugene Brusky*, Green Bay, with a score of 75. The Senior event trophy, awarded for first low gross by a physician 50 or more years of age, was won by *Dr. Francis L. Hummer*, Madison. *Drs. Donald Peterson*, Madison, and *William Funcke*, Beaver Dam, tied for first low net with scores of 73.

Election of officers was held at the evening dinner. Elected for president was *Dr. Conde Conroy*, Milwaukee; vice-president, *Dr. William J. Madden*, Racine; and secretary-treasurer, *Dr. Norman Erdman*, Manitowoc.

Milwaukee Academy of Surgery Formed

Organization of the Milwaukee Academy of Surgery, a group of board certified surgeons who will hold six scientific meetings annually, was announced recently. Membership is open to certified surgeons who have practiced at least three years in the community. There are 51 charter members.

The first meeting was held in October at the Milwaukee Children's Hospital. Officers are: *Drs. Irwin Schulz*, president; *Kendall Sauter*, president-elect; *Albert Martin*, secretary-treasurer; *Joseph Darin*, recorder; and *Henry Twelmeyer*, *Shimpei Sakaguchi*, and *James Conley*, councilors.

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SPECIALTY SOCIETIES *continued*

Wisconsin Psychiatric Association

The Annual Scientific Meeting of the Wisconsin Psychiatric Association will be held Jan. 31–Feb. 1, in Madison. Housing may be had at the Park Motor Inn, 22 S. Carroll St. The meetings will be held in the State Medical Society building, 330 E. Lakeside.

Theme of the meeting will be "Wisconsin Psychiatry—1964." The program has been tentatively outlined to include on Friday: registration at 10 a.m., keynote address at 11 a.m., and scientific sessions for the remainder of the day. Saturday's program will include scientific sessions, a business meeting at 4 p.m., and the concluding banquet at 7:30 p.m.

Northern Wisconsin Dietetic Association

The annual meeting of the Northern Wisconsin Dietetic Association was held in September at Green Lake. The featured speakers were *Dr. Hugh J. McLane*, Fond du Lac; John H. Guill, Jr., director, Chicago FDA; Mrs. Marge Luetke, Ripon businesswoman; and Miss Mary K. Watts, dietary supervisor, Milwaukee County institutions.

Wisconsin Radiological Society

The fourteenth annual meeting of the Wisconsin Radiological Society was held September 13 to 15, at Maxwelton Braes, Bailey's Harbor. Guest speakers were Drs. Harold O. Peterson, Minneapolis, Minn., and James Christie, Cleveland, O. Doctor Peterson is chairman of the Department of Radiology, University Hospitals, Minneapolis, and presented a review of myelography. Doctor Christie spoke on radioisotope scanning.

Other speakers were Drs. George Wirtanen, and John Alberti of Madison; and Drs. John Wallerius, *Daniel J. Price*, and Theodore Keller of Milwaukee.

Dr. Howard O. Bayley of Beaver Dam was elected president to succeed *Dr. Hobart H. Wright* of Milwaukee. *Dr. Theodore J. Pfeffer*, Milwaukee, was elected president-elect, and *Dr. Howard Mauthe*, Fond du Lac, was named vice-president. *Dr. Charles Benkendorf*, Green Bay, will continue to serve as secretary and treasurer for the next two years. *Dr. Joseph Wepfer*, Milwaukee, and *Dr. John Mokrohisky*, Green Bay, were elected to the board of directors, and *Dr. Robert W. Byrne*, Milwaukee, to the board of censors. *Dr. Robert Feulner*, Waukesha, was reelected as councilor to the American Board of Radiology with *Dr. Leslie Jones*, Racine, serving as the alternate.

New members accepted into the society were *Dr. Thomas G. Olsen*, Marshfield; *Dr. Albert Kohn*, Stevens Point; *Dr. James R. Nellen*, *Dr. James E. Ramin*, and *Dr. Richard Row Byrne*, all of Milwaukee.

The program chairman was *Dr. John Amberg*, Milwaukee, and the registration committee was composed of Mrs. Hobart Wright, Mrs. John Amberg, and Mrs. Howard Bayley.

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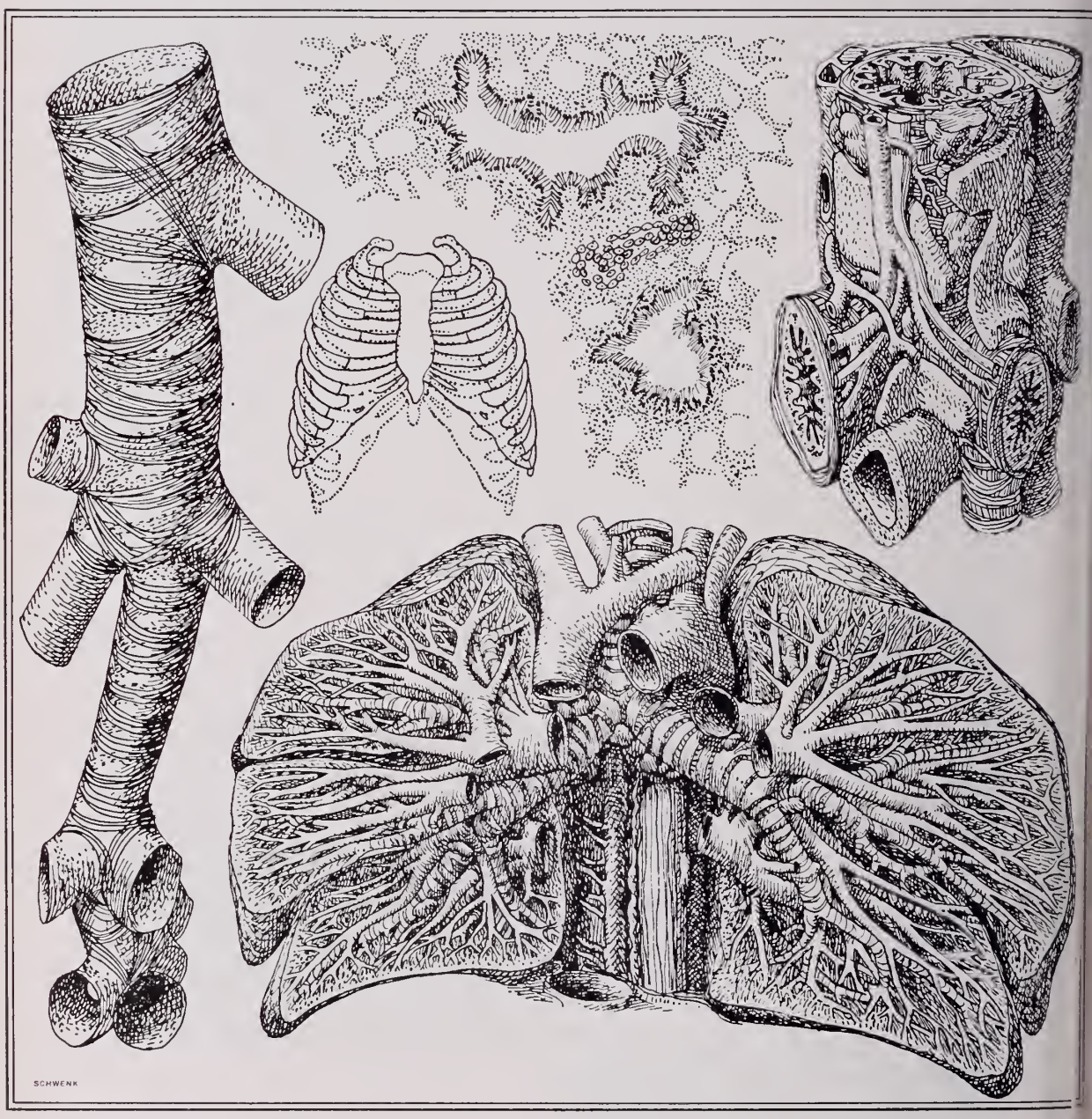

SCHWENK

NEWS OF WISCONSIN PHYSICIANS

Dr. La Brec Joins Gundersen Clinic

Dr. Henry C. La Brec, La Crosse, has joined the Gundersen Clinic and Lutheran Hospital staffs. Doctor La Brec received his M.D. degree from the University of Wisconsin Medical School after attending Johns Hopkins University and Lawrence College. He served one year's internship at Jackson Memorial Hospital, University of Miami, and three years in the Air Force as a general medical officer. He served residency in dermatology at the Milwaukee County Hospital and Veterans Administration Hospital, Milwaukee, and at the University of Pennsylvania.

Tuberculosis Symposium

Twelve Madison physicians participated in the annual Mississippi Valley Conference on tuberculosis in October in Minneapolis, Minn. They are: *Drs. Robert J. Samp, John H. Juhl,* Marvin Hinke, *Richard Wasserburger, John K. Curtis,* Edna M. Cree, *Bruce J. Longley, Halvor Vermund, Frank F. Gollin, Fred J. Ansfield, A. R. Curreri,* and *Robert O. Johnson.*

Dr. Reinert Joins Gundersen Clinic

Dr. John E. Reinert, a native of Wilmette, Ill., has joined the Gundersen Clinic and La Crosse Lutheran Hospital staffs as a specialist in neurosurgery and neurology. Doctor Reinert received his M.D. from the University of Illinois Medical School, Chicago, in 1946. He has had practices during the past five years in Omaha, Neb., Rapid City, S.D., and Boston. He is certified by the American Board of Psychiatry and Neurology and by the American Board of Neurosurgery. He is a member of the Harvey Cushing Society, the Academy of Neurology, and the Massachusetts State Medical Society.

Baraboo Medical Staff Elects Officers

Officers were elected at the annual meeting of medical staff members of St. Claire Hospital, Baraboo, held recently. *Dr. M. F. Huth,* Baraboo, was elected president, with *Dr. J. H. Houghton,* Wisconsin Dells, vice-president; and *Dr. H. L. Conley,* Wisconsin Dells, secretary-treasurer. The executive board and joint conference committee includes the officers and *Dr. C. R. Pearson,* Baraboo; Dr. K. D. Hannon, Baraboo; and *Dr. F. W. Gissall,* Wisconsin Dells.

Appointed to Northwestern Mutual

Dr. Hubert W. Simonsen, Janesville, has been appointed assistant medical director of Northwestern Mutual Life Insurance Company. He has been practicing internal medicine at the Janesville Medical Center for the past two years. He received his M.D. degree from the University of Wisconsin Medical School in 1957. Doctor Simonsen served a year internship and a three-year residency at the Milwaukee County Hospital.

Physicians whose names appear in italic are members of the State Medical Society.

Dr. Schorr Joins Marshfield Clinic

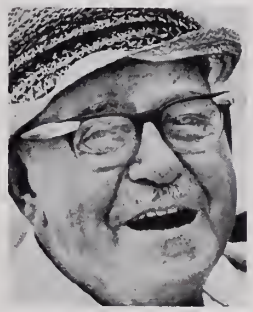
Dr. William F. Schorr, a native of Fond du Lac, has joined the Marshfield Clinic in dermatology. He received his M.D. from the Marquette University School of Medicine, Milwaukee, and interned at St. Mary's Hospital, Duluth, Minn. He served two years in the Army, then took residency at Jackson Memorial Hospital, Miami, Fla. As part of his training Doctor Schorr has been at Vargas Hospital, Caracas, Venezuela, for the last seven months doing clinical work and research on tropical disea es.

Dr. Pearce is Medical Director

Dr. Luther W. Pearce, a native of Kentucky, has assumed the full-time position of medical director of the Walworth County Counseling Center. He received his M.D. from Albany Medical College in 1955, then finished a rotating internship at Cincinnati General Hospital. He finished his psychiatric residency at Walter Reed General Hospital in 1960. Since then, Doctor Pearce has been chief, Mental Hygiene Consultation Service, Fort Lewis, Wash.; and for the past year was chief, Department of Psychiatry and Neurology, Madigan General Hospital, Tacoma, Wash.

Dr. Pippin Featured in Milwaukee Journal

Dr. B. I. Pippin, Richland Center, was featured recently in a personality sketch in the MILWAUKEE JOURNAL. Doctor Pippin, pictured as "a globetrotting fisherman . . . who flies his own plane," retired in 1960 after 46 years of medical practice, and spends most of the year in Islamorado, Fla.



Dr. B. I. Pippin

Dr. Jochimsen Addresses PTA

Dr. Earl Jochimsen, a psychiatrist with the Sheboygan Clinic, discussed emotional problems of children at the Chilton PTA meeting recently.

Dr. Collentine Discusses Medical Care

Dr. George E. Collentine, Jr. Milwaukee, discussed the question of medical care for the aged, as proposed in the pending King-Anderson bill, at a recent Rock County Medical Society and Auxiliary meeting in Janesville.

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Oshkosh Northwestern Photo

Three Oshkosh physicions proved their interest in the community blood progrom recently by being the first donors to the Red Cross collection in Oshkosh. Dr. E. J. Zmolek (left), Mercy Hospitol chief of stoff, is shown next to Corol Curtin, R. N., (center), ond Dr. Leslie H. Stone. Dr. John B. Hughes is shown on the toble.

Dr. Petersik Named Chief of Staff

Dr. John T. Petersik, Oshkosh, has been named chief of staff and president of the Mercy Hospital medical staff, Oshkosh. He succeeds *Dr. E. J. Zmolek* who is the immediate past president of the medical staff. Other officers elected are *Dr. Harvey Monday*, vice-president, and *Dr. Leslie H. Stone*, secretary, both of Oshkosh. Department heads are *Dr. H. M. Hillenbrand*, surgery; *Dr. E. N. Wright*, obstetrics; and *Dr. J. B. Hughes*, medicine. Chairman of the staff nominating committee was *Dr. J. V. Meli*. All are from Oshkosh.

Dr. Neeno Speaks at PTA

Dr. Katsumi Neeno, Janesville pediatrician, opened the Adams PTA year with a talk on "School and Your Child's Health," in September.

Participants in Disaster Medical Care

Wisconsin physicians who participated in the Eleventh Annual National Conference on Disaster Medical Care, held June 15, at Atlantic City, N.J., by the Council on National Security of the American Medical Association, were: *Drs. E. A. Bachhuber*, of the Marquette medical school, Milwaukee; *James H. Barbour*, of the University of Wisconsin medical school, Madison; *W. J. Egan*, president of the State Medical Society, Milwaukee; and *L. O. Simenstad*, member of the Council on National Security of the AMA, Osceola.

Edgerton Medical Staff Hosts Clergy

The Memorial Community Hospital medical staff, Edgerton, hosted clergymen from the Edgerton and surrounding area recently. The theme of the joint meeting was "Treating the Whole Patient." *Dr. M. D. Davis*, Milton, was moderator for the panel discussion with the Rev. V. O. Aronsen speaking for the clergy and *Dr. V. S. Falk, Jr.*, Edgerton, speaking for the medical staff.

Dr. Jurisic Goes to Spring Valley

Dr. Anthony Jurisic, a native of Yugoslavia, has begun practice in Spring Valley. He received his M.D. in Yugoslavia, and completed his internship at Colombus Hospital, Chicago. Since then, he has been with the Illinois State Board of Health at the Chicago State Hospital.

Dr. Van Hecke Aids United Fund

Dr. L. J. Van Hecke, Milwaukee, county medical examiner, is chairman of the physicians' section of the United Fund drive in Milwaukee.

Dr. Meyer Speaks on Heart Research

Dr. Thomas Meyer, Madison, spoke at Tomahawk recently on the research being done by the Wisconsin Heart Association. Fifty cents out of every Heart Fund dollar is spent for research, he said. Doctor Meyer, assistant professor of pediatrics, University of Wisconsin Medical School, is an active member of the Heart Association.

Dr. Pavik Joins Edgerton Clinic

Dr. Kenneth W. Pavik, Verdigre, Neb., has recently become associated with the Edgerton Clinic. A 1959 graduate of Creighton University, Omaha, Neb., he served his internship at St. Elizabeth Hospital, Lincoln, Neb., and then served three years with the U. S. Navy; consisting of sea duty with MSTS in the North Pacific and shore duty at Treasure Island.

Dr. Anderson Reopens Hospital

Dr. Norbert O. Anderson, Daggett, has gone to Haiti to reopen a hospital on the island of La-Gonave. It is a facility which he established several years ago for the Wesleyan Methodist Mission. Doctor Anderson is associated with Dr. John Heidenreich, at the Menominee County Clinic.

Talk on Diabetes

Dr. John H. Esser, Milwaukee, president of the Wisconsin Diabetes Association, was the speaker for the second meeting in a series of four concerning diabetes, held recently at Berlin Hospital.

Grant to Dr. Curreri

The U. S. Public Health Service has awarded a $659,865 grant to the University of Wisconsin for continuation of a cancer research project headed by *Dr. Anthony R. Curreri*, Madison. The grant for "Human Pharmacology of Anti-Cancer Agents" will permit Doctor Curreri to continue the third year of his research project.

Attend Heart Session

Four faculty members of the University of Wisconsin Medical School attended the American Heart Association's Annual Meeting in Los Angeles, in October. Dr. William C. Boake, instructor in medicine, presented a paper. Delegates were *Drs. Charles W. Crumpton*, director of the cardiovascular laboratory; *George G. Rowe*, associate professor of medicine; and William B. Youmans, chairman of the physiology department.

Chair Presented to Dr. Reese

The Wisconsin Chair, a captain's chair emblazoned with the seal of the University of Wisconsin and awarded to emeritus members of the University Hospitals staff, was presented to *Dr. Hans Reese*, Madison, emeritus professor of neurology. *Dr. John H. Juhl*, Madison, professor of radiology, made the award at the Neurological and Rehabilitation Hospital. Doctor Reese, a native of Germany, founded the University's psychiatry and neurology departments 38 years ago. He is recognized internationally as an authority on unusual disorders of the nervous system.

Dr. Prickman Joins Dean Clinic

Dr. William E. Prickman has recently become associated with the Dean Clinic, Madison, in the practice of ophthalmology.

Correction

In the September issue, page 28, in the article about *Dr. Jack A. Peterson*, who recently became associated with *Dr. Paul Carrol*, Waukesha, it was inadvertently omitted that, aside from a year of residency at the Medical Center, Hermann Hospital, Houston, Tex., he had also completed residency elsewhere. Doctor Peterson completed two years of residency in obstetrics and gynecology at Queens and Kapioloui Maternity and Gynecological Hospital, Honolulu, Hawaii, prior to assuming residency in Houston.

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PHYSICIAN NEWS *continued*

Book by Dr. Wasserburger

Dr. R. H. Wasserburger, Madison, associate professor of medicine at the University of Wisconsin Medical School and at the Veterans Administration Hospital, is author of a new book, THE NORMAL AND ABNORMAL UNIPOLAR ELECTROCARDIOGRAM IN INFANTS AND CHILDREN. The publication was supported by a grant from the Wisconsin Heart Association; Williams and Wilkins is the publisher.

Dr. Houfek Addresses Madison PTA

Dr. Edward Houfek, Sheboygan, spoke recently to the Madison PTA. He emphasized the first five years of a child's life as being the most vital in laying the foundations of mental health.

Dr. Samp Speaks at Mental Health Parley

Dr. Robert J. Samp, Madison, was the dinner speaker at Minnesota's first Leadership Conference on Mental Health, Minneapolis, in September.

Dr. Karsten Speaks to American Legion Auxiliary

Dr. Frederik Karsten, Horicon, spoke on the human heart, its functions and care, at a recent meeting of the Horicon American Legion Auxiliary.

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State Medical Society Honors Nineteen Doctors For Fifty Years' Service

Nineteen Wisconsin physicians were honored at the Annual Meeting of the State Medical Society in May when they were awarded memberships in the society's "Fifty Year Club."

Completing 50 years of service in the medical profession this year were: Drs. Alba C. Edwards, Baraboo; Karl K. Amundson, Cambridge; Hermann K. Rosmann, Cuba City; Hamilton A. Bolstad, De Soto; Paul J. Dailey, Elcho; Harvey R. Sharpe, Fond du Lac; John G. Hirschboeck, Forestville; Charles F. McCusker, Glenwood City; Edward F. Barta, Jeffrey J. Brook, Cornelius J. Corcoran, John T. Klein, Francis B. McMahon, and Arthur A. Pleyte, all of Milwaukee; George P. Dempsey, South Milwaukee; John E. Hanko, Reedsburg; Henry F. Hoesley, Shullsburg; Louis A. Seymer, Wauwatosa; and James P. Dean, Madison.

They received their awards at the State Medical Society's annual dinner which was held at the Hotel Schroeder, Milwaukee.

The doctors, all medical school graduates in 1913, represented a total of 950 years of experience in the medical profession. Eight are graduates of Marquette University School of Medicine's first class. Fourteen are general practitioners; the others are specialists in eye, ear, nose and throat, pathology, surgery and pulmonary diseases. They practiced in communities ranging in size from Forestville, population 324, to Milwaukee.

Doctor Edwards, a general practitioner, practiced in Arcadia and Reedsburg before coming to Baraboo in 1922. He practiced there for 32 years, retiring in 1954, and is a past president of the Sauk County Medical Society.

A general practitioner in Cambridge since 1914, Doctor Amundson is a graduate of the University of Pennsylvania Medical School. His father, also a physician, came to Cambridge in 1882, and the family has served the medical needs of the community for a total of 81 years.

A native of Germany, Doctor Rosmann practiced in El Salvador and New York before coming to Cuba City in 1939. He is a graduate of the University of Munich Medical School and a general practitioner.

Doctor Bolstad, a graduate of the University of Iowa Medical School, practiced in Boyden, Ia., before coming to De Soto in 1936. He is a general practitioner.

A graduate of Marquette University School of Medicine, Doctor Dailey has practiced in Elcho since 1913. He is a past president of the Langlade County Medical Society.

Doctor Sharpe, a graduate of the University of Illinois Medical School, practiced in Calumet, Mich., before coming to Fond du Lac in 1920. He is a Fellow of the American College of Surgeons and a past president of the Fond du Lac County Medical Society.

Doctor McCusker is also a graduate of Marquette University School of Medicine. A general practitioner, he established his practice in Glenwood City following service in World War I in the Army medical corps, he came to Madison in 1919 and practiced until his retirement in 1949. He is a past president of the Dane County Medical Society.

Doctor Hirschboeck, a graduate of Marquette University School of Medicine, has practiced in Forestville since 1917. He is a general practitioner with a special interest in surgery.

Doctor Barta, a specialist in pathology, is also a graduate of Marquette University School of Medicine. He has practiced in Milwaukee and has been assistant professor of pathology at Marquette.

A specialist in eye, ear, nose and throat, Doctor Brook practiced in Milwaukee from 1914 until his

Back row, l. to r.: Dr. John E. Hanko, Reedsburg; Dr. Hamilton A. Bolstad, De Soto; Dr. Jeffrey J. Brook, Milwaukee; Dr. Alba C. Edwards, Baraboo; Dr. John T. Klein, Milwaukee; Dr. Arthur A. Pleyte, Milwaukee. Front row, l. to r.: Dr. Karl K. Amundson, Cambridge; Dr. Paul J. Dailey, Elcho; Dr. Edward F. Barta, Milwaukee; Dr. Cornelius J. Corcoran, Milwaukee; Dr. Louis A. Seymer, Milwaukee; Dr. Harvey R. Sharpe, Fond du Lac.

retirement in 1949. He is a graduate of the University of Pennsylvania Medical School.

Doctor Corcoran, a specialist in gastroenterology, is a graduate of Marquette University Medical School. He has practiced in Milwaukee since 1914 and has served as an instructor at St. Mary's Hospital School of Nursing in Milwaukee.

A specialist in surgery, Doctor Klein practiced in Wauwatosa and Columbus and served with the Army medical corps in World War I before establishing his practice in Milwaukee. He was a graduate of Marquette University School of Medicine. Doctor Klein recently died.

Doctor McMahon, a specialist in surgery, is a graduate of the University of Pennsylvania Medical School. He established practice in Milwaukee following service in World War II and is a past president of the Milwaukee Academy of Medicine and associate clinical professor of surgery at Marquette University School of Medicine prior to his retirement.

Doctor Pleyte, also a Marquette graduate, is a former medical director of the Wisconsin Anti-Tuberculosis Association and a specialist in pulmonary diseases. He practiced in Delafield prior to joining the WATA in 1920. He was president of the Mississippi Valley Trudeau Society from 1933 to 1934 and of the Wisconsin Trudeau Society from 1946 to 1948. Doctor Pleyte retired in 1958.

A general practitioner in South Milwaukee since 1921, Doctor Dempsey is a graduate of Marquette University School of Medicine. He served with the Army medical corps in World War I.

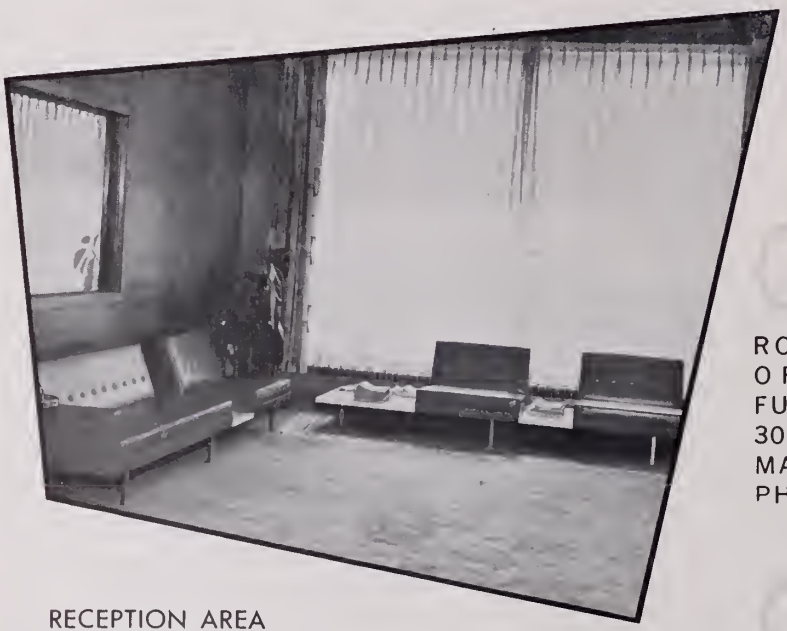
Doctor Hanko, also a Marquette graduate, practiced in Loganville and Cazenovia before coming to Reedsburg in 1942. He also was a public health official for 24 years.

A graduate of Loyola University Medical School, Doctor Hoesley practiced in Freeport, Ill., and New Glarus before coming to Shullsburg in 1916. He is a past president of the LaFayette County Medical Society and served two terms as mayor of Shullsburg.

A graduate of the University of Illinois Medical School, Doctor Seymer practiced in Chicago, Ill., and Elcho, Wis., prior to establishing his practice in Wauwatosa. He has been a general practitioner there for the past 43 years.

Dr. Bayley Receives Rotary Award

Dr. Howard G. Bayley, Jr., Beaver Dam, was presented the Beaver Dam Rotary Club's "Adult Volunteer Youth Worker Award" for 1963. Doctor Bayley was cited for his years of leadership in Boy Scouts, and his activity and support of church, community and club programs.



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MEMBERSHIP REPORT AS OF SEPTEMBER 13, 1963

SOCIETY RECORDS

NEW MEMBERS

Jergen L. Barber, 1300 University Avenue, Madison.
Frederick W. Blancke, 301 Troy Drive, Madison 4.
Peter N. Casey, 10425 West North Avenue, Milwaukee.
James D. Cherry, 1300 University Avenue, Madison.
John M. Coffey, 1415—14th Loop, S. B., Albuquerque, New Mexico.
Wanir C. Da Costa, 1707 Main Street, La Crosse.
A. Cartes del Rivero, 3046 North Cramer Street, Milwaukee.
James R. Ferwerda, 925 Glenview, Milwaukee.
Arthur E. Fitz, 5000 West Chambers Street, Milwaukee.
John J. Foley, 9636 West Capitol Drive, Milwaukee.
John V. Gehring, 130 East Walnut Street, Green Bay.
George P. Gersch, 134 North Leonard Street, West Salem.
Calvin J. Gillespie, 836 North 12th Street, Milwaukee.
William R. Halloran, 6900 North Port Washington Road, Milwaukee.
Alex M. Kane, 2576 North Frederick, Milwaukee.
Joseph C. Kiser, 1912 Atwood Avenue, Madison.
Ivan Knezevic, 4421 West Arthur Court, Milwaukee.
John A. Lind, 225 West Allen Street, Rice Lake.
Frank F. McBride, 3929 North Prospect Avenue, Milwaukee.
Donald J. Paluska, 533 North 90th Street, Milwaukee.
Earl E. Peters, 1344 Creston Park, Janesville.
Shafik A. Richany, Duke University, Pathology Department, Durham, North Carolina.
Doris M. Roob, 908 Milwaukee Avenue, Milwaukee
Jerry R. Salan, 105 Jefferson Street, Waupaca.
Thomas R. Sawyer, 625 North Milwaukee Street, Milwaukee.
Robert E. Steiner, 2266 North Prospect Avenue, Milwaukee.
Philip Shovers, 1212 West Wisconsin Avenue, Milwaukee.
Robert C. Tabet, 4762 North 103rd Street, Milwaukee.
John A. Walker, 6745 West Wells Street, Milwaukee.
Wilbert Wiviott, 536 West Wisconsin Avenue, Milwaukee.
Charles F. Wood, 120 North Main Street, Iola.

CHANGES OF ADDRESS

Angelina S. Allen, 301 Troy Drive, Madison.
Richard B. Anderson, 4410 Regent Street, Madison.
Ildefonso L. Asinas, Hales Corners, to 4204 South Howell Avenue, Milwaukee.
Richard M. Asma, 8200 North 43rd Street, Milwaukee.
D. W. Bailey, Dearborn, Mich., to 8303 Connecticut NE, Albuquerque, New Mexico, 87110.
C. E. Bellehumeur, 8200 North 43rd Street, Milwaukee 9.
D. J. Beltran, 2013 North 74th Street, Wauwatosa 13.
Edwin L. Bemis, 620 North 19th Street, Milwaukee.
Merle M. Bermann, 930 East Bay Point, Milwaukee 17.
John J. Brandabur, 4410 Regent Street, Madison.
Elvin M. Bremer, Nargerth, Pa., to 18301 Malden, Apt. 4, North Ridge, California.
Donald M. Britton, 4410 Regent Street, Madison.
Henry Brown, Madison, to 818 Harrison Avenue, Boston 18, Massachusetts.
Richard J. Bukoskv, Madison, 309 East Elizabeth Avenue, Linden, New Jersey.
Patrick L. Callen, 732 South 29th Street, Milwaukee.
C. D. Carlson, Eau Claire, to 2901 West Mt. Vernon Avenue, Milwaukee 8.
William P. Chalos, 10425 West North Avenue, Milwaukee 13.
Capt. James D. Collins, Jr., Madison, to Carswell Air Force Hospital, % Laboratory, Carswell Air Force Base, Texas.
Paul M. Cunningham, 420 East Longview, Appleton.
Richard A. Damon, Waupun, to 708 Scott Street, Beaver Dam.
Donald P. Davis, Carlinville, Ill., to 1814 East Wood Place, Shorewood.
Joseph M. Dockery, Racine, to 288 La Cumbre Road, Santa Barbara, California.
C. W. Docter, Spring Valley, to Plum City.
Charles A. Doehlert, 4410 Regent Street, Madison.
Edgar End, Wauwatosa, 7610 West Center Street, Milwaukee 22.
Jordan N. Fink, Milwaukee, to 718 Mulford, Evanston, Illinois.
Timothy T. Flaherty, Amarillo, Texas, to 101 Doty Street, Racine.
Adam Fueredi, Merrill, to Route 2, Box 275 A, Cedarburg.
Donald J. Garland, Shullsburg, to 7011 East Fourth Street, Tucson, Arizona.
Robert S. Gearhart, Madison, to 2509 East Elm Street, Tucson, Arizona.
Stafford W. Gedge, Marshfield to 109–11¼ Street, SW, Rochester, Minnesota.
Jack E. Geist, 3036 North Stowell, Milwaukee.
K. S. George, 8410 West Cleveland, Milwaukee.
J. J. Gramling, Jr., 10425 West North Avenue, Milwaukee 13.
Joseph J. Gramling, Sr., 10425 West North Avenue, Milwaukee 13.
T. J. Greenwalt, 2370 North Terrace Avenue, Milwaukee.
Raymond L. Hansen, Colby, to 1452 Durand Court, Rochester, Minnesota.
James R. Hanson, Oceanside, Calif., to 3125 Colby, Everett, Washington.
John W. Harkness, San Francisco, to American Embassy, % Peace Corps, Manila, Philippines.
J. B. Leith Hartman, New Berlin, to 2821 East Belleview Place, Milwaukee 11.
J. W. House, Jr., Milwaukee, to 85 Totten Place, Fort Leonard Wood, Missouri.
Francis Lee Hummer, 4410 Regent Street, Madison.
Michael T. Jaekels, 8303 West Silver Spring Drive, Milwaukee.
Darrell A. Jaques, Houston, Texas, to William Beaumont General Hospital, El Paso, Texas.
Elmer E. Johnson, 4510 Regent Street, Madison.
William P. Jones, Milwaukee, to 1000 Ward Avenue, Honolulu 14, Hawaii.
O. F. Kaarakka, 1159 North Osborne Boulevard, Racine.
Henry R. Karlin, 7635 West Oklahoma Avenue, Milwaukee 19.
Ronald P. Karzel, Madison, 2020 East Milwaukee Street, Janesville.
Thomas A. Kegel, 3191 South 83rd Street, Milwaukee.
William F. Kennedy, Milwaukee, to 1131 Oak Street, Neenah.
Joyce C. Kline, 1300 University Avenue, Madison.

SOCIETY RECORDS *continued*

R. J. Krill, 8200 North 43rd Street, Milwaukee 9.
G. M. Kroncke, Madison, to U. S. N. Hospital, Navy #3923, Box 44, APO San Francisco, California.
P. G. La Bissoniere, 10425 West North Avenue, Milwaukee 13.
David J. La Fond, 10425 West North Avenue, Milwaukee 13.
James M. Lee, Long Beach, Calif., to 3850 Dove Street, San Diego, California.
Leonard Lieberman, 9035 Watertown Plank Road, Milwaukee.
Edmund R. Liebl, 2712 Marshall Court, Madison.
John P. Locksmith, Clovis, N. M., to 969 Buckeye Drive, Ferguson, Missouri.
Renate E. Madsen, 4821 Bayfield Terrace, Madison.
Isadore Mallin, West Allis, to 2710 North Grant Boulevard, Milwaukee.
John D. Maloney, Valdosta, Ga., to 563 Harley Drive, Apt. 1, Columbus 2, Ohio.
John R. Marks, Black River Falls, to 1007 Lake Terrace Drive, Tumwater, Washington.
Thomas J. Martens, Fort Ord, Calif., to USA Tripler General Hospital, APO 438, San Francisco, California.
R. J. Mayer 5625 Washington Avenue, Racine.
Robert W. McCabe, 10425 West North Avenue, Milwaukee.
Wayne L. McFadden, South Milwaukee, 600 Main Street, West Lafayette, Ohio.
Frederick Melms, Jr., New York City, to Red Cedar Clinic, Menomonie.
Edmund Mensing, 714 East Glendale Avenue, Milwaukee.
Kilian H. Meyer, 1313 West Seminary Street, Richland Center.
William S. Middleton, Madison, to 735½ Northeast 25th Street, Oklahoma City 5, Oklahoma.
Sonja D. Monson, Madison, to V. A. Hospital, Minneapolis, Minnesota.
Silvanus A. Morton, Milwaukee, to American University of Beirut, Beirut, Lebanon.
Delbert P. Nachazel, Jr., Des Plaines, Ill., to 102 East Main Street, Waukesha.
M. Pinson Neal, Jr., Madison, to 1200 East Brood Street, Richmond 19, Virginia.
Thomas M. O'Connor, 3014 North 46th Street, Milwaukee.
Mae J. O'Donnell, Excelsior Springs, Mo., to V. A. Center, Wadsworth, Kansas.
William J. O'Leary, South Milwaukee, to 2517 South 4th Street, Salina, Kansas.
Martin H. Olson, Wittenberg, to 1324 Schofield Avenue, Schofield.
R. J. O'Malley, 8200 North 43rd Street, Milwaukee.
Jack A. Peterson, Houston, Texas, to 508 Summitt Avenue, Waukesha.
Donald O. Price, 4410 Regent Street, Madison.
George James Pugh, 7808 North Regent Road, Milwaukee 17.
Flavio Puletti, 1300 University Avenue, Madison.
Frank J. Pulito, 1915 West Hampton Avenue, Milwaukee.
Henry C. Rahr, Luxemburg, to 832 Forest Hill Drive, Green Bay.
Thomas H. Rees, 104 North 8th Street, Manitowoc.
Mac C. Roller, San Francisco, to 619 Walnut, Whiteland, Indiana.
A. I. Rosenberger, 1200 West Bradley Road, Milwaukee 17.
William C. Rouman, Milwaukee, to 13335 Gremoor Drive, Elm Grove.
Marvin E. Royce, Mayville, to P. O. Box 452, Honokaa, Hawaii.
R. C. Ryan, Arpin, to Box 152, Tomah.
K. M. Sachtjen, 2715 Marshall Court, Madison.
James R. Schmidt, Menomonee Falls, to 6026 West Washington Avenue, Wauwatosa 13.
C. D. Schoenwetter, 4410 Regent Street, Madison.
Kenneth P. Schroeder, Berlin, 702 Vera Court, Apt. 2, Madison.
Eugene P. Schuh, 1507 Doctors Court, Watertown.
Cleon L. Schultz, Madison, to Lancaster Dourse, Colby College, Watertown, Maine.
James T. Schulz, Coronado, Calif., to General Delivery, Wauwatosa 13.
John L. Sella, Mount Calvary, to 431 North 49th Street, Milwaukee.
Edward T. Sheehan, 111 East Wisconsin Avenue, Milwaukee.
Edwin O. Sheldon, Jr., Fort Carson, Colo., to 1552 University Avenue, Madison.
Rodolfo G. Simeon, Lancaster, to 635 Main Street, Reedsburg.
Raymond E. Skupniewicz, 5625 Washington Avenue, Racine.
Hartwick M. Stang, Eau Claire, to RFD 3, Hayward.
Michael Stoklos, 150 South Calhoun Road, Brookfield.
Estil Y. Strawn, 1515 West North Avenue, Milwaukee.
Gojko D. Stula, 8410 West Cleveland, Milwaukee 27.
William A. Tanner, 4410 Regent Street, Madison.
John H. Turgeson, 4410 Regent Street, Madison.
Kenneth Urlakis, 6001 West Center Street, Milwaukee.
A. P. Vastola, Jr. 4410 Regent Street, Madison.
Alejandro M. Vinluan, 5501 North 76th Street, Milwaukee.
Thomas F. Way, Madison, to 290 East 15th Street, Merced, California.
Richard R. Whereatt, Munster, Ind., to 709 Washington Street, Manitowoc.
Sherwyn M. Woods, March AFB, Calif., to 14155 Magnolia Boulevard, Van Nuys, California.
Thomas E. Zabors, Milwaukee, to 1427 Camden Avenue, Los Angeles 25, California.
A. B. Zautcke, Jr., 8430 West Capitol Drive, Milwaukee.
A. A. Zeps, 1220 Dewey Avenue, Milwaukee.

REMOVED FROM MEMBERSHIP

Thomas B. Davis, Winnebago County, transferred to Michigan.
Bernard F. Kalina, Brown County, transferred to New York.
Evelyn D. Lipp, Dane County, resigned.
David A. Werner, Sheboygan County, resigned.

DEATHS

Alphonse M. Bodden, Milwaukee County, June 17, 1963.
Hector C. Marsh, Shawano County, June 27, 1963.
Ulrich Senn, Milwaukee County, July 2, 1963.
Herman A. Aageson, Oconto County, July 3, 1963.
John B. MacLaren, Outagamie County, July 13, 1963.
William O. Sydow, nonmember, July 16, 1963.
Edward A. Waldeck, Milwaukee County, July 29, 1963.
Branko Radich, Winnebago County, July 30, 1963.
Clarence K. Schubert, Dane County, August 7, 1963.
Enoch F. Peterson, Milwaukee County, August 12, 1963.
Vincent J. Guzzetta, Milwaukee County, August 17, 1963.
William J. Allen, Rock County, August 22, 1963.
John C. Harman, La Crosse County, August 28, 1963.
David M. Daley, La Crosse County, August 30, 1963.
H. P. Maxwell, Milwaukee County, September 2, 1963.
Robert S. Vivian, Rock County, September 2, 1963.
Milton Trautmann, Sauk County, September 6, 1963.

1963 **Wisconsin**

Nov. 19–20: Conference on Extension of Voluntary Health Insurance, sponsored by Wisconsin Physicians Service, at State Medical Society Headquarters, Madison.

Nov. 20–21: Third annual Milwaukee Medical Conference, at Milwaukee County Hospital, sponsored by the Medical Society of Milwaukee County.

Nov. 21: Eberbach Memorial lecture honoring Milwaukee Hospital centennial, by Dr. Carl E. Badgley, professor of orthopedic surgery, University of Michigan School of Medicine, Milwaukee.

Nov. 22: All-day symposium on Industrial Back Injuries, Mount Sinai Hospital, Milwaukee.

1964

Jan. 29: UW/SMS "In Depth" Teaching Program on Cardiology, Room 300, Wisconsin General Hospital, 1300 University Avenue, and State Medical Society Building, Madison.

Feb. 20: UW/SMS "In Depth" Teaching Program on Orthopedics, Room 300, Wisconsin General Hospital, 1300 University Avenue, and State Medical Society Building, Madison.

Feb. 24–29: Wisconsin Work Week of Health, State Medical Society Headquarters, Madison.

Mar. 19: UW/SMS "In Depth" Teaching Program on Endocrinology, Room 300, Wisconsin General Hospital, 1300 University Avenue, and State Medical Society Building, Madison.

Apr. 2–3: Annual Meeting, Wisconsin Anti-Tuberculosis Association, Coach House Motor Inn, Milwaukee.

Apr. 4: Annual Meeting, Wisconsin Thoracic Society (WATA medical section), Coach House Motor Inn, Milwaukee.

May 11–13: Scientific program of Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

1963 **Out-of-State**

Nov. 13–Dec. 10: First Pan-Pacific Mobile Educational Lecture Seminar, New Zealand, Australia, Thailand, the Philippines, Hong Kong and Japan.

Nov. 23: Annual meeting, American Rhinologic Society, Illinois Masonic Hospital, Chicago.

Nov. 30–Dec. 5: 22nd Annual Meeting of the American Academy of Dermatology, Chicago, Ill.

Dec. 1–4: Clinical Meeting, AMA, Portland, Ore.

Dec. 2–6: Course in Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Ambassador Hotel, Los Angeles.

1964

Jan. 5–8: First Annual Postgraduate Seminar in Anesthesiology, Miami Beach, Fla., sponsored by the University of Miami and University of Florida schools of medicine.

Jan. 9–11: International Symposium on Anticoagulant Therapy in Ischemic Heart Disease sponsored by Miami Heart Institute at Fontainebleau Hotel, Miami Beach, Fla.

Jan. 12–18: Tenth Annual General Practice Review, University of Colorado School of Medicine, Denver.

Jan. 13–17: Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Hotel Fontainebleau, Miami Beach.

Jan. 30–31: Symposium of Scintiscanning in Clinical Medicine, Department of Radiology of Bowman Gray School of Medicine, Winston-Salem, N. C.

MEDICAL MEETINGS

POSTGRADUATE COURSES

Jan. 30–Feb. 1: 28th Annual Session of the International Medical Assembly of Southwest Texas, Granada Hotel, San Antonio, Texas.

Feb. 2–8: Workshop in Teratology, University of Florida, Gainesville.

Feb. 7–8: Congress of the Professions, Lansing, Mich.

Feb. 17–19: Canadian-American Medical and Dental Ski Association meeting, Harbor Highlands, Harbor Springs, Mich. Sec-Treas: T. J. Trapasso, M.D., 816 Ashmun St., Sault Ste. Marie, Mich.

Mar. 1–6: American College of Allergists Graduate Instructional Course, Twentieth Annual Congress, Americana Hotel, Bal Harbour, Miami Beach, Fla.

Mar. 16–19: American College of Surgeons, New Orleans, La.

Apr. 13–16: American Industrial Health Conference, Pittsburgh-Hilton Hotel, Pittsburgh, Pa.

May 5–15: Postgraduate course in "Introduction to Fundamentals of Reconstructive Surgery of the Nasal Septum and External Pyramid," University of Cincinnati College of Medicine and Christ Hospital, Cincinnati.

June 15–19: Postgraduate course in psychiatry for internists, American College of Physicians, Psychiatric Institute and General Hospital, University of Maryland School of Medicine.

May 11–14: Annual scientific meeting, Aerospace Medical Association, Americana Hotel, Bal Harbour, Miami, Fla.

May 25–27: Annual meeting, American Thoracic Society, medical section of the National Tuberculosis Association, New York City.

June 15–19: Postgraduate course in Psychiatry for Internists, sponsored by the American College of Physicians, at Psychiatric Institute and the General Hospital of the University of Maryland School of Medicine.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, Council on International Affairs of the American College of Chest Physicians, Mexico City, Mexico.

Correction

The September issue of the Journal incorrectly listed the Eighth International Congress on Diseases of the Chest, sponsored by the Council on International Affairs of the American College of Chest Physicians, as occurring in 1963. The correct dates are Oct. 11–15, 1964. The Congress will be held in Mexico City.

International Symposium on Anticoagulants

An International Symposium on Anticoagulant Therapy in Ischemic Heart Disease will be held on Jan. 9–11, 1964, at the Fontainebleau Hotel, Miami Beach, Fla. This symposium is sponsored by the Miami Heart Institute under the chairmanship of E. Sterling Nichol, F.A.C.P. The faculty is com-

posed of 40 outstanding clinicians, from the United States, Canada, and abroad, experienced in the use of the anticoagulant in ischemic heart disease.

Controversial opinions on the virtue of anticoagulants in angina pectoris, "impending" and "acute" myocardial infarction will be presented. The management of long-term anticoagulant therapy will be discussed fully. The registration fee of $45 includes three luncheons and one dinner and show. Discussions will be chiefly clinical rather than technical. Entertainment is planned for the wives by the Auxiliary of Miami Heart Institute. Special hotel rates prevail for those attending the symposium.

If any further information is desired, please write to: Anticoagulant Symposium Committee, Miami Heart Institute, 4701 North Meridian Avenue, Miami Beach 40, Fla.

International Medical Assembly of Southwest Texas

The 28th Annual Session of the International Medical Assembly of Southwest Texas will be held in San Antonio, at the Granada Hotel, Jan. 30–Feb. 1, 1964. In addition to the scientific program, there will be many social events for the physician and wife. Those interested in receiving further information or registering may write Dr. William M. Center, or Mr. S. E. Cockrell, Jr., 202 West French Place, San Antonio, Texas 78212.

AMA Clinical Meeting, Post-Session Tours

Physicians, medical society executives and others who attend the American Medical Association Clinical Meeting in Portland, Ore., this December, have an opportunity to return home via Hawaii or Mexico.

The Multnomah County Medical Society (Portland) will sponsor two fully escorted post-session tours, leaving Portland, December 5.

Included in the 8-day Mexico tour are visits to Acapulco, Cuernavaca, Taxco, and Mexico City. A highlight of the tour will be a special morning seminar with Mexican physicians. Cost of the fully escorted, expense-paid Mexico tour is $205.50 per person, plus jet air fare.

Persons participating in the 8-day Hawaiian tour will stay at the Hawaiian Village Hotel on Waikiki Beach before visiting the island of Kauai, where they will spend three nights at the Kauai Surf Hotel. The Hawaii tour—also fully escorted—is $195 per person, plus jet air transportation.

Additional information and special post-session tour folders may be obtained from the Multnomah County Medical Society, 2164 S.W. Park Place, Portland 5, Ore.

American Academy of Dermatology

More than 1,300 dermatologists and other physicians will assemble in Chicago November 30 to December 5 for the 22nd Annual Meeting of the American Academy of Dermatology.

The six-day program of special courses, lectures, symposia, informal discussions, case presentations on film and a residents' forum will mark the 25th anniversary of the founding of the organization of skin disease specialists.

Scientific events during the remainder of the meeting will include 22 symposia, three special lectures, 58 informal discussions sessions (held twice a day), a forum for graduate students of dermatology, a day-long clinicopathologic conference and the showing of nine case presentations on film.

Six awards will be presented to scientific exhibitors for presentations in two categories—those representing original work and those with high teaching value.

Postgraduate Course in Nasal Surgery

An international postgraduate course in "Introduction to Fundamentals of Reconstructive Surgery of the Nasal Septum and External Pyramid" will be presented at the University of Cincinnati College of Medicine and Christ Hospital, Cincinnati, May 5–15, 1964.

Further information may be obtained from Dr. Raymond L. Hilsinger, 2403 Auburn Avenue, Cincinnati 19, or American Rhinologic Society, 530 Hawthorne Place, Chicago 57.

Scintiscanning Symposium

On January 30–31, 1964, a Symposium on Scintiscanning in Clinical Medicine will be held in Winston-Salem, N. C., sponsored by the Department of Radiology of the Bowman Gray School of Medicine.

Subjects to be covered will include the physical, electrical, and pharmacologic principles of organ scanning as well as specific discussions of brain, thyroid, parathyroid, heart, lung, liver, spleen, kidney, pancreas and bone scanning.

Registration will be limited to 200. For details write to J. L. Quinn, III, M.D., Nuclear Medicine, Bowman Gray School of Medicine, Winston-Salem 7, N. C.

UW/SMI "In Depth" Teaching Programs

The morning meetings of the teaching programs for Cardiology, January 29, Orthopedics, February 20, and Endocrinology, March 19, will be held in room 300 (third floor) of Wisconsin General Hospital, 1300 University Avenue, Madison, instead of SMI Auditorium as previously announced. Because so few physicians have used the bus service, there will be no bus from the State Medical Society to University Hospitals. Adequate parking is available at the Randall Avenue lot just north of 1400 University Avenue, behind the old Nurses Dormitory. Physicians attending the teaching program should identify themselves, and their parking will be paid for by the State Medical Society. Spaces for doctors' cars will be reserved in the front of the parking lot at the State Medical Society, 330 East Lakeside, for those who attend the luncheon and the conference in the afternoon.

Classified Advertisements

Advertisements in this section are accepted in two categories: PHYSICIANS' EXCHANGE and COMMERCIAL.

RATES: 10¢ per word, with a minimum charge of $4.00 per ad. Additional insertions of same ad at one-half price each, maximum time one year. Display: $10.00 per column inch.

DEADLINE: Copy must be received by the 15th of the month preceding month of issue. Send copy to: Wisconsin Medical Journal, Box 1109, Madison 1, Wis.; or phone Alpine 6–3101.

PHYSICIANS' EXCHANGE: This section is limited to physicians and others desiring physician placement, sale of medical practice or equipment of a physician, sale or lease of medical buildings, etc. Advertisements from individual members of the State Medical Society of Wisconsin are accepted without charge. Widows of deceased member physicians are allowed to advertise without charge. The rates quoted above apply to ads placed by clinics and others. There is no additional charge for ads with Dept. numbers. For these ads, address replies to: Dept. ___, % Wisconsin Medical Journal, Box 1109, Madison 1, Wis. Advertisers using Dept. numbers forbid the disclosure of their identity. All inquiries are forwarded to them immediately.

COMMERCIAL: Advertisements are accepted at the above rates from individuals, firms, organizations, etc., who are reputable, have a good credit rating and advertise products or services of ethical standards. The Journal reserves the right to reject any advertising. Advertisements from member physicians are also accepted at the above rates.

PHYSICIANS' EXCHANGE

FOR SALE: GENERAL PRACTICE in industrial city of approximately 50,000 in central Wisconsin. Fully staffed, fully manned 275-bed open staff hospital. Good recreational facilities. Should gross $35,000 the first year. Contact Dept. 64 in care of the Journal. m8tfn

FOR SALE: Established EENT practice, over 40 years in the heart of Milwaukee. Excellent referrals; will introduce; retiring. Contact Dept. 24 care of the Journal. m12tfn

FOR SALE: GENERAL PRACTICE. In beautiful northeastern Wisconsin where two doctors are covering potential of 10,000 people. Drastic need of a doctor, preferably two, to take over the practice of deceased physician. Office has large waiting room, two consultation rooms, examining room, two treatment rooms, laboratory, and library. A pharmacy is adjacent to the building. Equipment of the highest quality and TRAINED PERSONNEL ready to help you. Good hospital in town. Practice has great surgery potential. Townspeople will help you if you are the right person. Contact Mrs. H. A. Aageson, Oconto, Wis. Please supply references with your reply. m9–11

WANTED: GENERAL PRACTITIONER for association with two-man group located near Madison. Excellent hospital and recreational facilities. Salary open to start with partnership opportunity at end of one year. New building with excellent equipment and personnel. Contact Dept. 52 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER as associate. Immediately available opportunity to practice in well established group of two. Replacement for sudden loss of partner. Eventual partnership. 126 E. Main Street, Madison. AL 6–3171. m9tfn

WANTED: GENERAL PRACTITIONER as a replacement in town of 1,275 in southern Wisconsin. Gross receipts $42,000 in 1961, over $24,000 first 6 months 1962. Unopposed, good schools, churches, roads, fishing. Nearby accredited 200 bed hospital. Leaving for residency. Contact: D. L. Minter, M.D., Clinton, Wis. m9tfn

WANTED: PHYSICIAN with military service fulfilled to associate with a general surgeon also in general practice in northeastern Wisconsin in a city of 75,000. Excellent salary leading to early partnership. This is an A-1 financial opportunity. An early interview is appreciated. Contact Dept. 43 in care of the Journal. m4tfn

WANTED: INTERNIST, Board certified, to join two established surgeons. Excellent office facilities. Opposite 300-bed hospital—200-bed added expansion in progress. Town of 15,000. Central Wisconsin. Guaranteed salary. Percentage and partnership early prospects. Contact Paul F. Doege Medical Center, 512 St. Joseph Ave., Marshfield, Wis. m3tfm

OFFICE SPACE for two or three physicians, OB or two surgeons. To rent or to sell. Pharmacy in same building. Contact Dept. 33 in care of the Journal. m3tfn

GENERAL PRACTICE FOR SALE. Physician desiring own x-ray equipment may purchase radiographic, fluoroscopic and therapy equipment. Seven-room office on main corner in southern Wisconsin city of 35,000 occupied for over 40 years. Wish to retire. Reasonable price. Contact Dept. 19 in care of the Journal. m11tfn

PARTNER IN GENERAL PRACTICE WANTED in Green Lake county, town of 5,000. Fifty-bed private hospital Five grade schools and one high school. No predominant nationalities. Various churches. Main occupations are leather, fur and metal. Contact Dept. 20 in care of the Journal m11tfn

STOPPED MEDICAL PRACTICE, ill health. For sale: Burdick EKG; high speed centrifuge, hematocrit centrifuge; steel office furniture, all new since 1957; office instruments; one repaired Hamilton table and cabinet; one new Hamilton cabinet; steel shelving etc.; and hydraulic table. John A. Booher, M.D., Reedsburg. m9tfn

EXCELLENT OPPORTUNITY for PSYCHIATRIST or physician interested in psychiatry to become associated with Mendota Hospital medical team. Permanent Civil Service position with associated benefits. Salary $1,000 and upward per month, depending upon experience and training. Housing available at nominal charge. Regular work hours. Staffed by about 30 psychiatrists and/or physicians. Investigate now. W. J. Urben, Superintendent, Mendota State Hospital, Madison 4, Wis. g9tfn

FOR RENT NOV. 1: Approximately 1,000 sq. ft. office space, ground floor, at 304 N.E. Avenue, Waukesha. Ward Evenson, D.D.S., 306 N.E. Avenue, Waukesha, phone LIberty 7–8000. 10tfn

WANTED: YOUNG GENERAL PRACTITIONER who is interested in general medicine and obstetrics to associate with a small group in northwestern Wisconsin. Salary arrangements to start with early partnership. Contact Dept. 70 in care of the Journal. 10tfn

FOR SALE: Good working older type x-ray machine with fluoroscopic attachment. Takes excellent bone pictures. Price $200. D. J. Sievers, M.D., 118 Spring St., Berlin, Wis. m10–12

WANTED: PHYSICIAN. Capable general practitioner preferred. Challenging assignment, affording opportunity to fully utilize talents and knowledge. Chance to enjoy normal life. Unusual fringe benefits. Contact Chief of Staff, Veterans Administration Center, Wood (Milwaukee), Wis. Telephone EVergreen 4–2000, Extension 250. 10–12

RESIDENCIES in Physical Medicine and Rehabilitation offer ideal opportunity in a growing field to the general practitioner who has decided to specialize. Comprehensive training utilizing Mayo Clinic facilities and faculty, at $3,600 to $8,000 stipend. Attractive community with excellent school system and cultural advantages. Contact E. C. Elkins, M.D., Mayo Foundation, Rochester, Minn. p10–12

URGENTLY NEEDED: Associate going for residency—another man urgently needed. Twelve miles $1,300 or more monthly. No investment. Available east of Fond du Lac, Catholic rural area. Start at June. Contact Jos. F. Miller, M.D., Mt. Calvary, Wis. m4tfn

WANTED: INTERNIST, Board certified or eligible for association with young internist in southeastern Wisconsin city of 90,000. Contact Dept. 980 in care of the Journal. m4tfn

FOR SALE: IN WISCONSIN. General practice, well established, same location 40 years, fully equipped 7-room office. Will take any reasonable offer and finance as you wish. Poor health forces retirement. Contact Dept. 912 in care of the Journal. m4tfn

WANTED: PHYSICIAN to share a clinic which is now occupied by an M.D. and a D.D.S., located in a prosperous southeastern Wisconsin industrial and farming community where the need for another physician is very great. Contact Dept. 827 in care of the Journal. 4tfn

FOR SALE: PEDIATRICS PRACTICE in suburb of large Wisconsin city; will introduce; buyer assume two-year lease; open hospital staff; physician leaving Sept. 1, 1962, for academic post. Contact Dept. 985 in care of the Journal. m5tfn

FOUR-ROOM SUITE plus use of large, pleasant waiting room available in air-conditioned, modern allergy clinic. ENT or medical man (GP?)-(Pediatrician?) would find space unusually advantageous. Adjacent Capitol Court Shopping Center, northwest Milwaukee area. Contact Dept. 67 in care of the Journal. m9tfn

OFFICE SPACE in medical clinic, 2218 North Third Street, Milwaukee, Wis.; Co. 4–2800. m3tfn

WANTED: GENERAL PRACTITIONER to replace physician who left for residency training. Fully equipped office available immediately. Town of 2,100 offers good hospital, skiing, hunting, golf, fishing and many other recreational advantages along the Chippewa River near its junction with the Mississippi. Financial remuneration should be excellent from the start. Contact Dept. 7 in care of the Journal. m9tfn

WANTED: GENERAL PRACTITIONER for associate with two other general practitioners in community of 2,400 with trade area of 7,000 in Green county. No investment required. Excellent clinical and diagnostic facilities. 200 bed hospital 15 miles. Good educational facilities. Convenient communications to recreational areas. Contact M. W. Stuessy, M.D., Brodhead. m3tfn

GENERAL PRACTICE available immediately in Milwaukee, Wis. (southeast side). Established 35 years, busy active practice, excellent location, beautiful ground floor clinic building, air-conditioned. Contact Dept. 41 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER. Must be graduate of class A medical school, preferably with two-year internship from class A teaching hospital. Midwest industrial city of 46,000. Open staffed, fully equipped, 250-bed hospital. Equal partnership if satisfactory within two years. Excellent recreational facilities. Have well established general practice. Contact Dept. 57 in care of the Journal. m5tfn

WANTED: OB–GYN physician and a general practitioner with some general surgical training to associate with another physician. Beautiful, large, new, well-equipped office. Parking lot. Air-conditioned. Starting salary $1,000. Partnership. City 10,000; drawing area 20,000. North Central Wisconsin. Contract Dept. 46 in care of the Journal. m4tfn

WANTED: GENERAL SURGEON, well qualified, to join two man clinic group in community of 40,000. Excellent facilities and limitless opportunity. State qualifications and availability when contacting Dept. 61 in care of the Journal. m7tfn

WANTED: PSYCHIATRIST. County community 80,000. Two and one-half days per week at mental health center and county mental hospital. $16,000 annually. Administrator, Mental Health Center, 339 Reed Ave., Manitowoc, Wis. 11–12

WANTED: GENERAL PRACTITIONER as associate in a four-man group with adequate clinical facilities. Offer open for two or three year locum tenens or for permanent association in the group. Town of 4,000, well-equipped 80-bed hospital, in west central Wisconsin. Contact Dept. 10 in care of the Journal. m9tfn

GOOD LOCATION AVAILABLE for general practitioner. Nothing to buy. Will assist and refer all general practice cases. Contact C. A. Sholtes, M.D., Richland Center, Wis., Midway 7–2592 or 7–2544. m9tfn

FOR SALE: GENERAL PRACTICE, well trained and active, in new fully equipped clinic building. Present physician leaving for residency. Personnel well trained and efficient. Rural village 38 miles northeast of Madison. New school, swimming pool, good housing available. Subsidy can be arranged through village. Contact Joseph G. Brown, M. D., Cambria, Wisconsin. m6tfn

FOR SALE: GENERAL PRACTICE in Chippewa Falls, Wis.; well established, same location for 17 years, fully equipped 5½-room office. Will take any reasonable offer and finance as you wish. Office help available. Practice available because of recent death of William F. Janc, M.D. Contact Mrs. William F. Janc, 300 Macomber Street, Chippewa Falls, Wis. m7tfn

WANTED: Young general practitioner for association with 32-year-old established general practitioner. American graduate. Military obligation satisfied. Early partnership. City of 70,000, in the southeast corner of the state. Two large open staff hospitals. Contact Dept. 73 in care of the Journal. m11tfn

EENT SPECIALIST NEEDED for Eau Claire and vicinity, population 60,000. Could take over 20-year practice of deceased physician. Very advantageous opportunity. Contact Mrs. S. B. Russell, 114½ Grand Avenue West, Eau Claire, Wis. m3tfn

GROUP OF THREE desires general practitioner as associate. New clinic building with adequate facilities, in town of 5,500. Recent graduate preferable. Contact Plymouth Clinic, Plymouth, Wis. m4tfn

LOCATION WANTED: Either general practice or radiology or combination. Board eligible in radiology and experienced GP. Will serve several small hospitals in radiology, or will purchase retiring physician's equipment. Contact Dept. 51 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER, immediate full partnership in active practice now grossing $50,000, all advantages of dual practice with vacation periods and free weekends. No investment required. Full hospital privileges. Contact Dept. 53 in care of the Journal. m4tfn

WANTED: A two man partnership would like a general practitioner interested in internal medicine or an internal medicine man to become associated. Location is in north central Wisconsin. New hospital facilities are available as well as a large extensively equipped office. Contact Dept. 59 in care of the Journal. m7tfn

GENERAL PRACTITIONER for psychiatric treatment center. Excellent working conditions. Starting pay from $12,000 to $15,600 based on experience and training. State Civil Service status with associated benefits. Forty-hour week, paid holidays, vacation, retirement fund. Some on grounds housing for single, or small families. Hospital location on beautiful 300-acre Lake Mendota frontage site. Contact Dr. W. J. Urben, Superintendent, Mendota State Hospital, Madison 4, Wis. g9tfn

FOR SALE: The following equipment has been used and is all in good working condition: Castle sterilizer, 4x6x16", on stand. Cameron electrical surgical unit and electrodes, on stand. Electric headlights, many vaginal speculi, all sizes. Any reasonable offer will be considered. E. G. Welke, M.D., 1310 Morrison, Madison, Wis. Telephone ALpine 6–7606. m10tfn

FOR SALE: Equipment of retiring physician, including National cautery; 15 MA-120KV Profexray machine with table and accessories; Birtcher Crystal Bandmaster diathermy with surgical attachments; cold quartz ultraviolet light; various small instruments and treatment room supplies. Contact Mr. Harvey Schellpfeffer, 44 N. Main St., Mayville, Wis., Telephone 8. m11tfn

FOR SALE: Air-conditioned first floor office building, 1800 sq. ft., supplemental rental income from three dental offices upstairs. Owner in practice 13 years before leaving, had large, active practice. In city of Mayville, Wis., near Horicon marsh recreational area, state's largest cities for cultural, shopping activities. Open staff hospitals nearby. Contact Mr. Earl Anderson, 607 Seitz Ave., Mayville, Wis. m7tfn

FOR SALE: GENERAL PRACTICE in Prairie du Sac, Wis.; well established, same location for 15 years in fully equipped 4 room suite of offices, including small unit x-ray machine; ground floor clinic building, balance of space rented to dentist. Same office help for 15 years. Hospital facilities available in community, a rural village 27 miles northwest of Madison. New school, swimming pool and housing available. Office building and equipment may be purchased or rented. Practice available because of recent death of Milton Trautmann, M.D. Contact Mrs. Esther F. Trautmann, Prairie du Sac, Wis., or Attorney R. F. Curtin, Box 36, Sauk City, Wis. m9tfn

WANTED: PEDIATRICIAN for two-man department in 13-man multi-specialty group located in southern Wisconsin city of 37,000. Salary first two years, then share in profit. Excellent retirement and vacation policy. Contact Dept. 58 in care of the Journal. 6–11

WANTED: GENERAL PRACTITIONER or man with specialty who will do general practice and associate with one or two other men in well established practice. Fox River Valley. Immediate opening. Community of 50,000. Salary two years, then partnership. Contact Dept. 38 in care of the Journal. m4–5

WANTED: OPHTHALMOLOGIST for newly organized group in the Fox River Valley of Wisconsin. Community of over 50,000. Excellent living conditions, noted recreational area and above average opportunity. Salary two years then partnership. Contact Dept. 45 in care of the Journal. 4tfn

WANTED: GENERAL PRACTITIONER to join general practitioner in well established practice in southeastern Wisconsin. Town of 8,000. Class A accredited hospital. Salary or partnership if mutually agreeable. Contact Dept. 39 in care of the Journal. m3–5

URGENTLY NEEDED: General Practitioner to become associated with small clinic group in Milwaukee, Wis., preferably one who has had practical experience and a special interest in obstetrics or industrial surgery. First year, salary; then profit percentage leading to partnership. Contact Dept. 48 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER to replace retired physician in established three-man group. Must be interested in general medicine, obstetrics, and willing to assist in surgery. Fully equipped medical suite including x-ray and laboratory in town of 50,000 in Fox River Valley of Wisconsin. Unusual opportunity with eventual partnership. Contact Dept. 36 in care of the Journal. m3tfn

PHYSICIAN WANTED: General practitioner in northeastern Wisconsin wants part time help. Can use one man or combination to cover practice for week, month, or up to a year. Money no object for right man. No OB or surgery unless desired. Living facilities and car available. Contact Dept. 29 in care of the Journal. m1tfn

FOR SALE: Genophthalmic chair, Genophthalmic refractor, Claison projector, eye glass display cabinet, treatment table, records from eye, ear, nose and throat practice—42 years. Price very reasonable. J. J. Sharpe, M.D., 150 E. First St., Fond du Lac; telephone 291 and 349. m3tfn

WANTED: PHYSICIAN to associate with two established general practitioners in southeastern Wisconsin industrial, agricultural community of 6,000. Prefer one who has had special surgical or obstetrical training and willing to do general practice along with surgery or obstetrics. Contact Dept. 31 in care of the Journal. m1–3tfn

HELP! Two-man practice with only one man! General practitioner. Small town. Salary first year; partnership later. T. S. Westcott, M.D., 115 West Chestnut St., Pardeeville, Wis. m3tfn

GENERAL PRACTITIONER or internist to take over a thriving established practice in new northwest side of Milwaukee. Plan to specialize in one to two years. Office large enough for two physicians with x-ray and laboratory facilities. Willing to turn over entire practice. Equipment can be purchased at cost. Contact Dept. 65 in care of the Journal. m9tfn

WANTED: GENERAL PRACTITIONER to become associated with small group in central Wisconsin, preferably one who has had some practical experience, and has a special interest in obstetrics; also willing to only assist in surgery. Contact Dept. 969 in care of the Journal. m2tfn

WE NEED HELP!

Six-man general practice group needs help. Recent graduates, general practitioners seeking change, general surgeon.

New quarter million dollar building facilities. City of 5,000 in Wisconsin, with up to date 90-bed open hospital. Plenty of fishing, hunting, and outdoor recreation.

Starting salary open. Partnership two years. Fringe benefits excellent.

Phone collect 608–647–6161 or write Dept. 72 in care of the Journal. 11–1

INTERNIST WANTED for established group in Milwaukee suburb. One year salary then progression to equal ownership. Busy practice, good hospital, and office facilities. Fine opportunity. Contact Dept. 66 in care of the Journal. 9–11

FOR SALE: Microscope (E. Leitz Wetzlar Germany), Stryker cast cutter, medical instruments, Renwal sterilizer, Baumanometer (Kompak model), Detecto doctor scale, Tonsilectome and tips, Bard Parker utility syringe outfit, stethoscope (triple change), Kidde dry ice apparatus. Mrs. Cecile Arnoldussen, 1618 S. Willkie St., Appleton, Wis. m9tfn

VIRGINIA, MINNESOTA. Pop. 14,000, area pop. 80,000. St. Louis County. OB–GYN specialist wanted on partnership basis with 20 others. Excellent hospital. Office space available in modern clinic with complete laboratory and x-ray service. Living space available in new, modern houses or apartment. Main sources of income in area are farming, taconite, and mining. All churches represented and excellent school. Social activities available, hunting and fishing. Contact Donald L. Werner, M.D., East Range Clinic, Virginia, Minn. 9tfn

ASSOCIATE WANTED in general practice. $18,000 guaranteed clear per year. Should earn $30,000 clear after two years. Contact Jos. F. Miller, M.D., Mt. Calvary, Wis. m7tfn

FOR SALE: X-ray equipment, now located in Milwaukee. One Philips 250 KV 15 M therapy unit with metal and bakelite intracavitary cones, 7 years old, good condition. One 500 M. Westinghouse transformer, control stand, tilting table fluoroscopic screen with spot film device, kymograph body section unit. One 200 M Philips transformer, control stand tilting table, fluoroscopic screen. Contact Dept. 71 in care of the Journal. M10–2

ALLERGIST WANTED to share offices with dermatologist. Located in thriving area, south central Wisconsin. Unusual opportunity. Applicant must be board certified or qualified and intending to become certified. Reply, with details of personal and professional qualities and qualifications, to Dept. 5 in care of the Journal. m8tfn

FOR RENT: OFFICE SPACE, 1200 sq. ft., for medical offices in modern, air-conditioned building at 16 East Gorham Street, Madison. Available for immediate occupancy. Will accommodate one or two physicians, preferably internists. Off-street parking. Contact Robin Allin, M.D., 1313 Fish Hatchery Road, Madison, Wis., phone ALpine 6–5521; or residence CEdar 3–2082. m8tfn

PHYSICIANS, with or without pediatric training, needed in maternal and child health program at salaries ranging from $9,960.00 to $13,200.00. Five-day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, Milwaukee Health Department, Municipal Building, Milwaukee 2, Wis. g8tfn

WANTED: MEDICAL DIRECTOR for institution for the retarded. Specialty in pediatrics or internal medicine required. Staff of five physicians plus consultants in all specialties. Salary $18,672 to $21,672 depending on qualifications. Write: Mr. John M. Garstecki, Superintendent, Southern Colony and Training School, Union Grove, Wisconsin. g8tfn

INDEX TO ADVERTISERS

American Tobacco Co. ---------- 7
Ames Company, Inc. ---------- 63

Barr X-ray Co. ---------- 34
Beecher's—TV & Stereo ---------- 43
Borden's ---------- 38
Burroughs Wellcome & Co., Inc. ---------- 28, 51

Chatham Pharmaceuticals, Inc. ---------- 11
Chicago Medical Society ---------- 48

Davies, Rose & Company, Ltd. ---------- 44

Endo Laboratories ---------- 13

Geigy Pharmaceuticals ---------- 21, 22, 23, 24
Glenbrook Laboratories ---------- 32

Haug Drug Company ---------- 4, 56
Hotel Schroeder ---------- 4
House of Bidwell, Inc. ---------- 34
Hurley X-ray Company ---------- 38

Johnson & Johnson ---------- 8, 9

Keeley Institute, The ---------- 44

Lilly and Company, Eli ---------- front cover, 18
Lederle Laboratories ---------- 17, 25, 36, 37
Lov-e ---------- 6

Medical Protective Company, The ---------- 12
Milwaukee Sanatarium Foundation ---------- 38

Parke, Davis & Company ---------- 2, 3
Physicians' Exchange ---------- 59, 60, 61

Rennebohm's ---------- 38
Robins Co., Inc., A. H. ---------- 29, 30
Roche Laboratories ---------- back cover
Rogers Memorial Hospital ---------- 12
Rorer, Inc., William H. ---------- 55
Rowley & Schlimgen ---------- 46

Sacred Heart Sanitarium ---------- 62
St. Croixdale Sanatarium ---------- 4
St. Mary's Hill Hospital ---------- 48
Searle & Co., G. D. ---------- 19
Shorewood Sanitarium ---------- 34
Smith Kline & French Laboratories ---------- 10
Spence-McCord ---------- 43

Time Insurance Company ---------- 34
Tutag & Co., S. J. ---------- 35

Wallace Laboratories ---------- 11, 14, 15, 26, 27, 47, 52, 57
Winthrop Laboratories ---------- 16, 20, 58
Wisconsin Physicians Service ---------- 40, 41

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MILWAUKEE, WISCONSIN

An institution conducted for the diagnosis and treatment of mild nervous disorders and non-infectious diseases; also for rest and recuperation under medical supervision. Equipped with every modern facility for diagnostic purposes. Scientific dietetics, physiomechanotherapy, hydrotherapy, supervised occupational and recreational activities. Fully accredited. Literature and rates sent on request.

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the wisconsin medical journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

CONTENTS

Vol. 62, No. 12 DECEMBER 1963

SCIENTIFIC ARTICLES

Esophageal Hiatus Hernia, by I. D. Baronofsky, M.D., Ph.D., San Diego, California -- 495
Treatment of Undisplaced Carpal Navicular Fractures When Diagnosis Has Been Delayed, by G. F. Pratt, M.D., Rhinelander -- 498
Experimental Wound Infection and Its Prevention By Topical and Parenteral Techniques, by R. P. Gingrass, M.D., A. S. Close, M.D. and E. H. Ellison, M.D., Milwaukee ------ 501
Present Day Treatment of Dupuytren's Disease, by W. H. Frockelton, M.D., and J. L. Teasley, M.D., Milwaukee ---------- 505
Clinicopathologic Conference, by L. W. Kleppe, M.D., Beloit ---------- 507

SPECIAL ARTICLES

Oxytocics: Employment and Safeguards (obstetrical brief), by J. R. Evrard, M.D., Milwaukee ---------- 500
Roentgen Riddle, by D. J. Price, M.D., Milwaukee ---------- 504
Catastrophy of the Abruptio Placenta (obstetrical brief), by F. J. Hofmeister, M.D., Milwaukee ---------- 506
Public Health Nursing: A Family-Centered Service, by Ione M. Rowley, R.N., Madison 511
Bicillin Prophylaxis Program, by Patricia McIllece, M.D., Madison ---------- 512
Minutes of Council Meeting, Madison, July 27–28, 1963 ---------- 517
Wilson Cunningham Day . . . First Memorial Lecture ---------- 525
Reports Presented to the House of Delegates at Interim Session, Madison, October 18–19, 1963 ---------- 527
Transactions of House of Delegates, Interim Session, October 18–19, 1963, Madison -- 541
Leaders in Voluntary Health Insurance Exchange Views on Extension, Expansion -- 560
MD Calls for Teamwork to Prevent Sports Injuries ---------- 566
Official Call for Scientific Exhibits, 1964 Annual Meeting, Milwaukee, May 11–12–13 27
Dr. Duer Presents X-Ray Tubes to CES Foundation ---------- 45
Artificial Heart Valve For Humans Developed at University of Wisconsin ---------- 47
Index to Volume 62, January 1963-December 1963 ---------- 66

EDITORIALS

President's Page: We Can, in 1964, Avoid the Royal Road to Ruin, by W. J. Egan, M.D., Milwaukee ---------- 513
In Memoriam: J. F. K. ---------- 515
In the National Spotlight ---------- 516

REGULAR FEATURES

Letters ---------- 11
County Society Proceedings ---------- 29
Specialty Society Proceedings ---------- 31
News of Wisconsin Physicians ---------- 37
Facts About Wisconsin Physicians Service -- 50
Obituaries ---------- 51
Medical Meetings ---------- 59
Physicians' Exchange ---------- 63
Index to Advertisers ---------- 74

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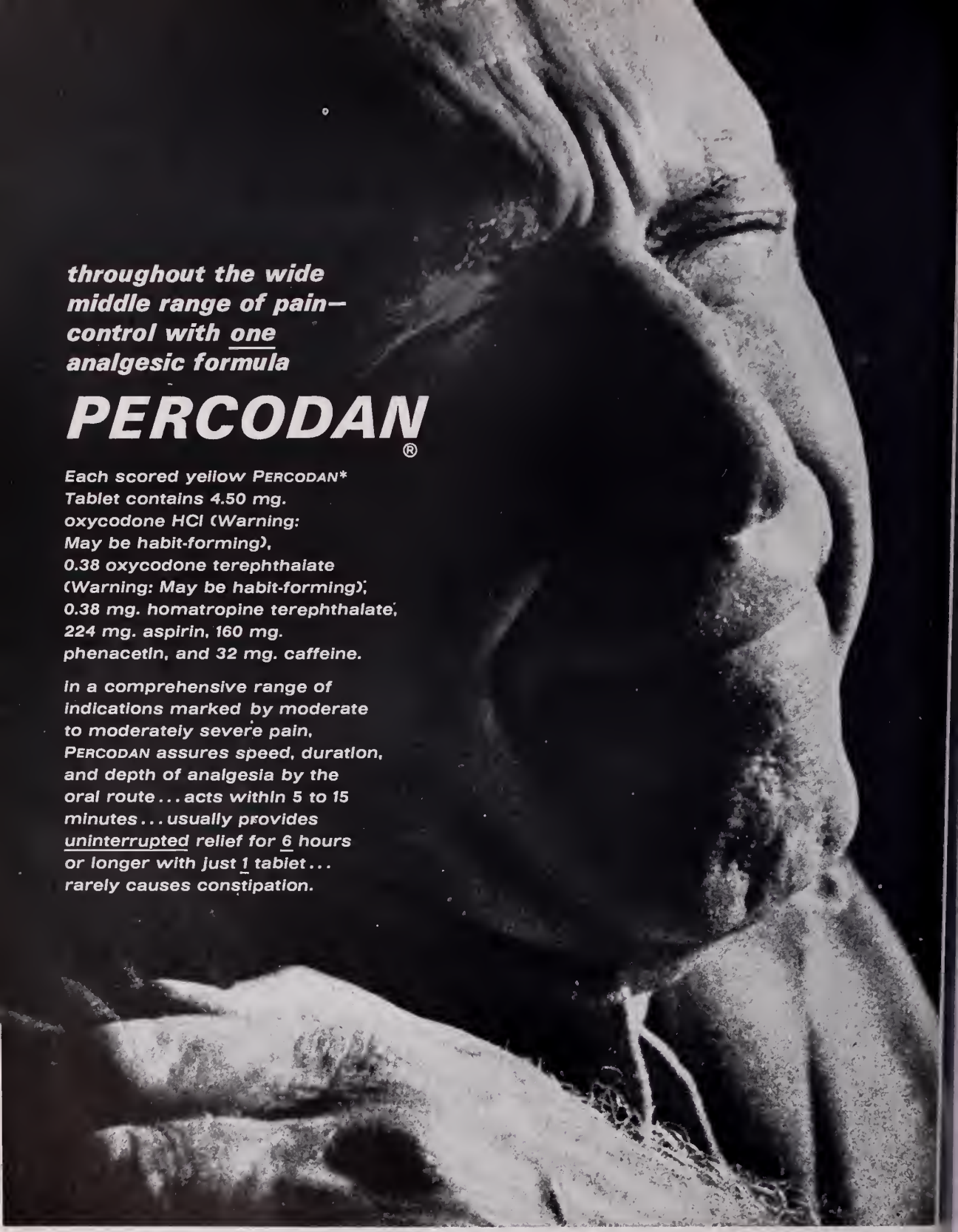
Journal
Established 1903
Annual Subscription-------$6.00
Single Copy---------- 1.00
Previous Years'---------- 2.00

ADVERTISING REPRESENTATIVES: State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Illinois; and Business Management Services, Inc., Park Ridge, Stevens Point, Wisconsin.

Second-class postage paid at Madison, Wisconsin. PUBLISHED MONTHLY. "Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized August 7, 1918." Address all communications to THE WISCONSIN MEDICAL JOURNAL. Street address: 303 East Lakeside Street. Mailing address: Box 1109, Madison 1, Wisconsin.



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LETTERS

SEAT BELTS

To DOCTOR EGAN:

I am sure you are aware of the recent decision by the automobile manufacturers to install, effective Jan. 1, 1964, seat belts as "standard equipment" in their 1964 model cars. Needless to say, we of Automotive Crash Injury Research (ACIR) are pleased with this decision that can affect the lives and well being of many thousands of motorists.

Of course, we feel that the programs carried on by the ACIR during the past years have contributed in no small way to this decision. At the same time, we recognize that the various reports of ACIR stressing the importance of this safety device could not have been made without your cooperation and that of the members of your Society. You can certainly take great pride in the contributions made and indeed great satisfaction in knowing that this work has resulted in such a decision.

Please extend to each member physician our appreciation for their deep interest and cooperation.

JOHN R. THOMPSON, *Field Representative*
Automotive Crash Injury Research
Cornell University

LEAD POISONING

To SMS:

Two recent articles concerning lead poisoning have appeared in newspapers citing the statistic, "70% of deaths due to poison in the pre-school age group are caused by lead poison." We have looked into this allegation thoroughly and find it to be in error.

In order to set this matter to rights, and perhaps forestall subsequent reprints of this erroneous report, we cite the United States Department of Health, Education, & Welfare Public Health Service, Division of Accident Prevention report dated December, 1962. In 1960 (the last year recorded), 445 deaths due to accidental poisoning involving children under 5 years of age are recorded. Seventy-eight of these, or *17.5%*, are attributed to lead and its compounds. Over the 10-year period covered in this report, 1951 through 1960, the percentage figure stands at 12.5%.

This office will be pleased to help you with all statistical and other matters related to lead toxicology.

DON G. FOWLER
Director of Health and Safety
Lead Industries Association, Inc.
292 Madison Ave.
New York 17, N. Y.

VOLUNTARY ADMISSION OF MENTALLY RETARDED CHILDREN UNDER THREE YEARS OF AGE

To SMS:

For a long time those of us involved in providing residential care for the mentally retarded have been faced with a greater demand for service than our facilities can accommodate. As a consequence it has been necessary to establish "waiting lists" for which there is no legal authority, but reality has dictated that those most in need of institutional care and service should be given priority for admission. Due to the excellent cooperation of parents, courts and agency officials this informal arrangement has worked out fairly well. To a large extent the patients presenting the most urgent needs have been admitted to one of the colonies within a reasonable time. There are, however, many others whose needs are not as urgent, who may have remained on the "waiting list" for a considerable length because there is no room. It is our hope that we may some day achieve the goal of having a bed available for all mentally retarded who require institutional care and treatment. With expanding and improved services for the mentally retarded at the community level the possibility of achieving this goal seems more realistic than ever before.

With the opening of Central Wisconsin Colony and Training School in 1959, a substantial new service was made available to the mentally retarded in Wisconsin. From the beginning Central Colony was planned to provide intensive medical and nursing services for the severely handicapped as well as to train personnel and engage in research. Included in the facilities at Central Colony is a large nursery building designed to serve young children. With the opening of the nursery building, all young children were transferred from Northern and Southern Colonies to Central Colony, and as a matter of policy all children who have not reached their third birthday are now admitted to Central Colony from the community by transfer from the other colonies.

The law requires that all mentally retarded persons shall be committed to either Northern or Southern Colony and the admission of committed patients to Central Colony can only be accomplished by transfer. This requirement does not apply to patients admitted by voluntary application (Section 51.10(1), Wisconsin Statutes). For various reasons, usually related to overcrowding, very few patients

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing.

Address all correspondence to:
THE EDITOR
WISCONSIN MEDICAL JOURNAL
Box 1109
Madison, Wisconsin 53701

have ever been admitted to our colonies by voluntary application.

For the present, at least, the nursery facilities at Central Colony are adequate to care for all mentally retarded children who have not reached their third birthday who require institutional care. Therefore, it seems desirable to arrange admission for these children by voluntary application of the parents or legal guardian, except in those cases where a legal commitment is necessary to accomplish admission or to protect the rights of the child.

We are, therefore, recommending to the courts, to other officials, agencies, parents and other interested individuals that whenever possible the voluntary admission procedure be used for mentally retarded children who have not reached their third birthday. It is to be understood that our recommendation is made only in the interest of expediting appropriate services to these children and their families, and in no way is intended to interfere with the authority of the courts in committing these children when indicated for the protection of their rights and their health and welfare.

To consider the possibility of admission the parent or legal guardian of the mentally retarded child should contact the Superintendent of Central Wisconsin Colony and Training School.

It is our hope that our recommendations meet with your approval and will serve in the interest of the patients and their families. If there are any questions or suggestions please let us hear from you.

WILBUR J. SCHMIDT, *Director*
Department of Public Welfare
State of Wisconsin

FILM ON ULCERATIVE COLITIS

To WMJ:

Long the subject of many studies, ulcerative colitis, marked as it is by exacerbations, remissions, and serious complications, still presents many unsolved and baffling problems. Dr. N. C. Hightower, Jr., and his associates have drawn from their extensive clinical experience at Scott and White Clinic in Temple, Texas, to prepare a 16-mm. color-sound film (running time 31 minutes). This film, "Diagnosis and Medical Management of Chronic Ulcerative Colitis," presents, in full-color, endoscopic views of ulcerative colitis with particular emphasis on its diagnosis, pathology, complications and treatment.

Physicians who have seen it are enthusiastic about its use both in teaching situations and as an important contribution to medical society and convention film programs.

Since this is a profes ional service of Pharmacia Laboratories, the film is available without charge for medical audiences. Additional information on ulcerative colitis in the form of reprints and bibliography is available from this office upon request.

L. ARLIN ELWINGER
Pharmacia Laboratories Inc.
501 Fifth Avenue
New York City

POSTHERPETIC NEURALGIA

To WMJ:

There is no need for post neuralgic pain of herpes simplex. Two cubic centimeters of pituitary extract hypo will stop all pain in one hour and will leave a soft scar. Dust with corn starch freely.

R. H. GRAY, M. D.
Onalaska, Wisconsin

(Editor's Note: Doctor Gray's statement is in response to an abstract which appeared in the September 1963 issue of the WMJ on page 370. Doctor Gray also noted in his letter that he had satisfactorily treated himself with this method. Doctor Gray has been a member of the State Medical Society since 1914.)

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OFFICIAL CALL
for Scientific Exhibits

1964 ANNUAL MEETING, MILWAUKEE, MAY 11–12–13

★

The Commission on Scientific Medicine is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1964 Annual Meeting. The exhibits will be located in Bruce Hall of the Milwaukee Auditorium.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space in the 1964 meeting are requested to file an application BEFORE FEB. 1, 1964, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed.

In-state exhibitors will have the following facilities provided by the State Medical Society: Velour booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, special lighting equipment, and half the cost of any drapes rented (rented through Badger Flag and Decorating Company at time exhibit is installed).

Booths for scientific exhibits will have dark maroon velour background, 8′ in height, and 8′ velour side dividers (such as is shown in illustration at right).

No exhibit may exceed a height of 7′ from the floor.

Counters (3′ high and 20″ wide) or tables (30″ high and 3′ wide) are available for viewboxes or displays to be raised above floor level.

Spaces can be allocated in 10′ units.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit by Feb. 1, 1964. *No applications can be accepted after that date.* Address your communications to:

JOHN K. CURTIS, M. D.
Director of Scientific Exhibits
% State Medical Society of Wisconsin
Box 1109
Madison 1, Wisconsin

Use form on following page

APPLICATION

FOR PARTICIPATION IN THE SCIENTIFIC EXHIBIT

1964 Annual Meeting — Milwaukee — May 11–12–13

★

Fill out the following information and mail to:

JOHN K. CURTIS, M. D., *Director of Scientific Exhibits*
State Medical Society of Wisconsin
Box 1109, Madison 1, Wisconsin

1. Title of exhibit: _____

2. Description of exhibit (space allowed below for 200-word description): _____

3. The standard booth is 10′ wide and 8′ deep. Sides 8′ x 8′ so *sides as well as back used.* What is the *minimum* space your display will require? 1 booth—2 booths—(Check space needed)

   (Space is scarce so do not request more than is necessary)

In figuring space, bear in mind you can use up to 8′ on each side in addition to back wall space of 10′ (less than 8′ if your display fills the entire back wall width).

4. Will radiologic viewing boxes be used? If so, will you furnish them? _____
   (The State Medical Society does not have equipment of this character available).

5. Name of exhibitor: _____

6. Name of institution cooperating in exhibit: _____

COUNTY SOCIETY PROCEEDINGS

DANE

A talk by Dr. Robert C. Hickey, new head of the department of surgery, University of Wisconsin, Madison, and a tour of the University Hospitals' new radiotherapy facility highlighted the annual meeting of the Dane County Medical Society with faculty of the University of Wisconsin Medical Center November 12. About 100 physicians attended the evening session. Doctor Hickey discussed "Surgical Considerations of Ulcerative Colitis." *Dr. Frank Larson*, director of the University Hospitals' clinical laboratories, discussed "Diagnostic Enzymology." *Dr. Palmer Kundert*, Madison, president of the Society, presided, and *Dr. Edwin C. Albright*, professor of medicine and Assistant Medical School Dean for clinical affairs, moderated the clinical program.

A new member of the Dane County Medical Society is *Dr. Owen L. Felton*, Madison. He was born in Sheboygan and graduated from the University of Wisconsin Medical School in 1960. He served his internship at Madison General Hospital. Doctor Felton is currently a resident in pathology at Madison General.

At the meeting of the Dane County Medical Society Board of Trustees on November 12, it was the unanimous decision of the Board to carry out a mass oral polio immunization campaign for Dane County. The Dane County Medical Society will be the sole sponsor of the program. A steering committee under the direction of Drs. *William Ylitalo* and *William Bartlett* is in the process of coordinating the various phases of the program. The steering committee consists of the following physicians: *W. T. Russell* and *T. F. Heighway*, supply and distribution; *J. J. Brandabur* and *C. A. Doehlert*, purchasing and finance; *C. K. Kincaid* and *H. W. Mahaffey*, site selection; *H. K. Tenney, III* and *J. D. Cherry*, manpower; *C. W. Stoops* and *R. W. Shropshire*, publicity; *C. R. Weatherhogg* and *L. G. Crocker*, records and surveillance.

The vaccine will be administered in 2-drop dosage in distilled water or by dropper depending on the age group. Everyone in Dane County 2 months of age and older will be eligible to receive the vaccine. There are no significant contraindications to oral polio vaccine, except that it should not be given within 1 month of other live vaccines such as measles and smallpox vaccines.

The target dates for the 3 Sunday Clinics at 6-week intervals are as follows:

Type I Vaccine—Sunday, January 12, 1964

Type III Vaccine—Sunday, February 23, 1964

Type II Vaccine—Sunday, April 5, 1964

Physicians whose names appear in italic are members of the State Medical Society.

Twenty-four Clinic sites in Madison and Dane County will be selected for administration of the vaccine. The Dane County Medical Society will underwrite the cost of the entire program by asking for a donation of 25¢ per dose. No one will be refused because of an inability to pay. The goal of the program will be to immunize everyone in Dane County whether they have previously received Salk vaccine or not.

OZAUKEE

The Ozaukee County Medical Society met in Grafton in October. *Dr. Roger Laubenheimer*, Milwaukee, presented an address on the diagnosis and treatment of common skin diseases. *Dr. P. B. Blanchard*, Cedarburg, reported on the fall meeting of the House of Delegates of the State Medical Society, held in Madison.

PIERCE—ST. CROIX

The Pierce–St. Croix County Medical Society met at Jestrons Supper Club, Menomonie, on November 19, it was announced by *Dr. P. H. Gutzler*, secretary for the Pierce–St. Croix County Medical Society.

RACINE

The Racine County Medical Society held its annual business meeting on November 21 at St. Luke's Hospital, Racine. Election of officers was held as well as a discussion relative to the fee guide schedule. The program, as announced by *Dr. Leslie E. Jones*, Racine, secretary of the Society, consisted of a demonstration of transistor radio equipment for use of citywide communication.

The annual dinner dance was held by the Society at the Racine Country Club on December 3.

TRI-COUNTY

The Tri-County (Trempealeau–Jackson–Buffalo) Medical Society met November 26 at St. Joseph's Hospital, Arcadia. *Dr. George B. Murphy, Jr.*, La Crosse surgeon was the featured speaker. The annual meeting and election of officers was held.

The new president is *Dr. Elbert Daniels*, Arcadia.. *Dr. J. H. Noble*, Black River Falls, was reelected as secretary.

★

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LEROY WAUCK, Ph. D.
Clinical Psychologist
ROBERT TESTIN, Ph.D.
Clinical Psychologist

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SPECIALTY SOCIETY PROCEEDINGS

Wisconsin Assn. of Psychiatric Clinics for Children

The Wisconsin Association of Psychiatric Clinics for Children held its semi-annual meeting in Madison in November. Dr. Ralph Rabinovitch, Madison, spoke on "Indications and Contraindications for Residential Placement;" *Dr. Milton H. Miller*, Madison, director of the Wisconsin Psychiatric Institute, spoke on the Institute, its goals, purposes, and functions. The officers are: president, Dr. George F. Meisinger, Fond du Lac; secretary, *Dr. Randolph Kreul, Jr.*, Racine; and treasurer, Mrs. Florence Lawrence, Waukesha. Albert S. Lipp, Madison social worker, is president-elect, program chairman, and executive committee member of the Association. *Dr. Wilson S. Dunn*, Madison, and Wilbur C. Thomas, administrative director of the Dane County Guidance Center, Madison, are also members of the executive committee.

Wisconsin Psychiatric Association—Northern Chapter

The Northern Chapter of the Wisconsin Psychiatric Association met in Marshfield in October. *Dr. G. L. River*, Marshfield, discussed "Organic Causes of Neurotic Abdominal Pain," and Dr. C. J. Coombs, Marshfield, spoke on "Endocrinopathies as a Cause of Neurosis and Psychosis." Both are members of the department of internal medicine, Marshfield Clinic. *Dr. B. R. Lawton*, of the department of thoracic and general surgery, Marshfield Clinic, spoke on "Vascular Disease and the Senile Patient." David Hoff, Madison, spoke on "Estate Planning for Physicians." Also, *Dr. James S. Vedder*, Marshfield Clinic, discussed his experiences in Peru while on assignment aboard the U.S.S. Hope.

Wisconsin Allergy Society

The Wisconsin Allergy Society met in October in Marshfield at the Marshfield Clinic. Speakers for the one-day meeting were Dr. William Kopp, Madison; *Dr. Stephan Epstein*, Marshfield; *Dr. Mildred Stone*, Cuba City; Dr. Kenneth Matthews, the University of Michigan Medical School; and *Dr. James Vedder*, Marshfield. *Dr. Robert Heywood*, Marshfield, was host for the event. *Dr. John R. Talbot*, Madison, associate clinical professor of medicine, University of Wisconsin Medical School, was installed as the new president.

American Association of Medical Assistants

The American Association of Medical Assistants, at its annual convention, October 9–13, in Miami Beach, Fla., elected a Wisconsinite to its Board of Trustees. She is June Gillette, Sheboygan. The county membership award, for numerical increase, went to Rock County, Wis. It was announced that certification exams will be held in June 1964, in Georgia, Wisconsin, New York, Oklahoma, and California. The application deadline is February 15. The 1964 convention will be held in Oklahoma City, Okla., October 14–18.

Wisconsin Society of Plastic Surgeons

The Wisconsin Society of Plastic Surgeons held its annual meeting November 5. Officers were elected. They are: president, *Dr. William H. Frackelton*, Milwaukee; vice-president, *Dr. Frank D. Bernard*, Madison; and secretary-treasurer, *Dr. Jack L. Teasley*, Milwaukee.

The group officially changed its title from Wisconsin Society of Plastic Surgery to Wisconsin Society of Plastic Surgeons.

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto–Ophthalmic Society met November 26 in Milwaukee at the University Club. The program on "Uveitis" was presented by Dr. Dan Gordon, clinical professor of ophthalmology Cornell University Medical School.

Wisconsin Division, American Cancer Society

The annual meeting of the Wisconsin Division of the American Cancer Society was held in October at the Park Motor Inn, Madison. Robert O. McLean, Madison, executive secretary, said that more than

Three medical organization leaders discuss the role of the physician's aide at the seventh annual convention of the American Association of Medical Assistants in Miami Beach. Left to right are Miss Alice Budny, Milwaukee, immediate past president of the AAMA; Dr. Edward R. Annis, AMA president, and Mrs. Judy Coleman, Dallas, Tex., AAMA president.

Physicians whose names appear in italic are members of the State Medical Society.

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dependable: 'Miltown' (meprobamate) is an established drug. There are no surprises in store for you or your patient. You can depend on it to help your patients through periods of emotional distress — and to help maintain their emotional stability.

easy to use: Because 'Miltown' (meprobamate) is compatible with almost any other kind of drug therapy, you'll find it fits in easily with any program of treatment you are now using. It will not, therefore, complicate treatment of patients seen in clinical practice.

BRIEF SUMMARY: *Indications:* Anxiety and tension states, and all conditions in which anxiety and tension are symptoms. *Side Effects:* Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1-4 doses of the drug. *Contraindications:* Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. *Precautions:* Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities, to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available to physicians on request.*

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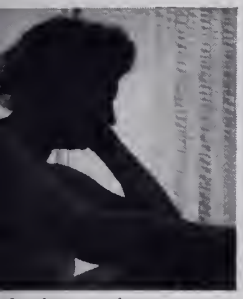
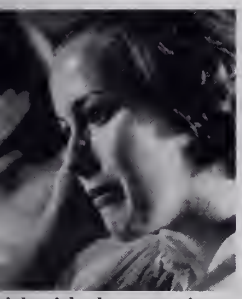

The insomniac

The tense, nervous patient

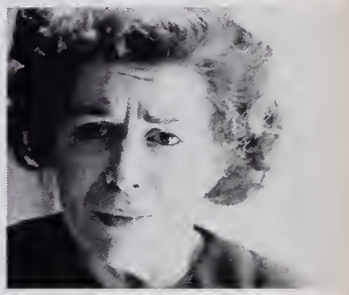
The heart-disease patient

The surgical patient

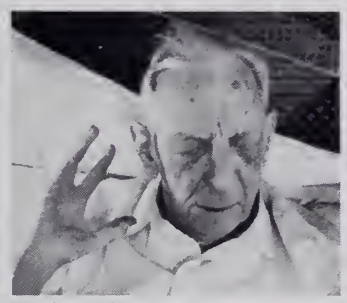

girl with dermatosis

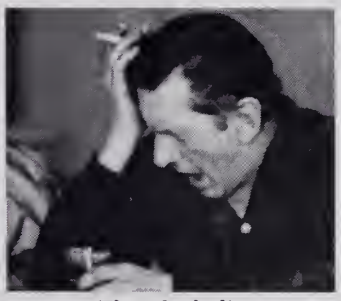
Tension headache

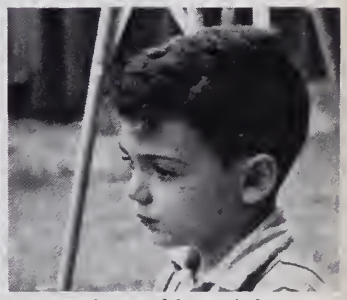
The woman in menopause


Anxious depression

menstrual tension


The agitated senile patient


The alcoholic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200 delegates, including representatives from the county units, unit officers, and volunteer workers, attended. Dr. Wendell G. Scott of the Scott Radiological group, Washington University School of Medicine, St. Louis, Mo., and president-elect of the American Cancer Society, was the main speaker at the evening banquet. Dr. R. K. Boutwell, associate professor of oncology at the University of Wisconsin, was the keynote speaker at the luncheon. Delegates toured the cancer research facilities at University Hospitals.

Dr. Glen A. Smiley, Delavan, was elected president of the Wisconsin Division of the American Cancer Society. Other officers chosen were: the Rev. Perry H. Saito, Stevens Point, and Mrs. James D. Swan, Jr., Lake Geneva, vice-presidents; J. Kenneth Conlin, Madison, treasurer; and R. O. McLean, Madison, secretary and executive director. Mrs. Donald Morrisey, Appleton, was elected chairman of the executive committee. Executive committee members are: *Dr. William D. Stovall*, Madison; G. H. Stordock, Waupaca; *Dr. James R. Hoon*, Sheboygan; *Dr. Norman O. Becker*, Fond du Lac; *Dr. Ralph C. Frank*, Eau Claire; *Dr. Gail H. Williams*, Marshfield; Ernest P. Strub, Beaver Dam; Mrs. Francis J. Wilcox, Eau Claire; and William Shimpf, Watertown.

Lay delegates at large are: Col. Bently Courtenay, Fox Bluff, Madison; Mark Hoskins, Lancaster; G. H. Stordock, Waupaca; and Delbert J. Kenny, West Bend.

Medical directors are: Dr. Harold P. Rusch, Madison; Dr. Lee L. Bathke, Sheboygan; *Dr. Norman Becker*, Fond du Lac; and Dr. J. S. Frey, Beloit.

The delegates voted to grant Mrs. L. A. Leadbetter, Rhinelander, an honorary life membership in the Society's board of directors. Mrs. Robert Murray, Oshkosh, was elected to receive the 1963 Distinguished Service Award of the Wisconsin Division at the next meeting in 1964.

The 1962 award was presented to *Dr. Ralph C. Frank*, radiologist, Eau Claire. Patrick C. Krohn, Appleton, state crusade chairman, also received an award for meritorious work within the state.

Wisconsin Society of Internal Medicine

During the annual meeting of the Wisconsin Society of Internal Medicine, held at Sturgeon Bay, September 13 and 14, the following physicians were elected to membership: *Drs. Allen G. Brailey*, La Crosse; *Harold H. Fechtner*, Wausau; *Richard L. Franklin*, Milwaukee; *Louis F. Jermain*, Milwaukee; *Thomas R. Leicht*, Green Bay; *James D. Michael*, Sheboygan; *Thomas C. Puchner*, Milwaukee; *Thomas S. Sargeant*, Janesville; and *William L. Treacy*, Milwaukee. The Society has 200 members throughout Wisconsin.

New officers elected were: president, *Dr. William L. Coffey, Jr.*, Milwaukee; president-elect, *Dr. George E. Gutmann*, Janesville; secretary–treasurer, *Dr. John H. Wishart*, Eau Claire. Doctor Coffey succeeds *Dr. Warren K. Simmons*, Rhinelander, as president. Members of the council are: *Dr. A. A. Quisling*, Madison; *Dr. George R. Barry*, Monroe; Doctor Gutmann; Doctor Coffey; Doctor Simmons; Doctor Wishart; *Dr. Edward K. Ryder*, Madison; and *Dr. James W. Manier*, Marshfield. The Society will hold its 1964 annual meeting at Delavan, October 9 and 10.

New officers and councilors of the Wisconsin Society of Internal Medicine are shown above, left to right: Dr. A. A. Quisling, Madison, and Dr. George R. Barry, Monroe, councilors; Dr. George E. Gutmann, Janesville, president-elect and councilor; Dr. William L. Coffey, Jr., Milwaukee, president; Dr. Warren K. Simmons, Rhinelander, past president; Dr. John H. Wishart, Eau Claire, secretary-treasurer; Dr. Edward K. Ryder, Madison; and Dr. James W. Monier, Marshfield, councilors.

Dr. Haukohl on New Lab Assistant Board

Dr. Robert S. Haukohl, Milwaukee, is a member of the newly created Board of Certified Laboratory Assistants, which is sponsored by the American Society of Clinical Pathologists and the American Society of Medical Technologists.

UW Appointment Changes

The University of Wisconsin Medical Center was consolidated with three appointment changes approved by the Board of Regents. Acting Dean of the Medical School James F. Crow was given the additional title of Acting Director of the Medical Center; Superintendent of Hospitals Edward J. Connors was named Assistant Director of the Medical Center, and Medical School Business Manager Ralph A. Hawley was named Secretary of the Faculties of the Medical Center.

ACOG Participants

Several Wisconsin physicians participated in the District VI meetings of the American College of Obstetricians and Gynecologists (ACOG). At the Fourth Annual Conference on Obstetric, Gynecologic and Neonatal Nursing, held in Chicago at the Pick-Congress Hotel, October 17–19, *Dr. Ben M. Peckham,* Madison, was a guest speaker and addressed the group on "Early Diagnosis of Cancer."

At the District VI ACOG held November 21–23 at the Hotel Schroeder, Milwaukee, the following presentations were made: "Bilirubin Content of Amniotic Fluid," by *Dr. Joseph C. Fralich,* Racine, with *Dr. Richard T. Flynn,* Milwaukee, serving as discussant; "Effect of Massive Antibiotic Therapy for Pelvic Inflammatory Disease," by Dr. Paul Messinger, Milwaukee; and "Posterior Colpotomy: An Approach to Pelvic Surgery," by *Dr. George S. Woodward,* Milwaukee. *Dr. David V. Foley,* Milwaukee, served as a discussant on "Torsion of Cystic or Diseased Adnexal Tissue," and *Dr. William Kiekhofer,* Madison, moderated a panel discussion on oral contraceptives.

Also presented were: "Cesarean Section—Associated Surgery—Is It Justified?," by *Dr. Andrew Boyd, Jr.,* Milwaukee; "Office Gynecological Surgery," by *Dr. Herbert F. Sandmire,* Green Bay; "Surgical Care of the Incompetent Cervix," by *Dr. Richard C. Brown,* Eau Claire; and "Use of Frozen Plasma in Pseudohemophilia," by *Dr. William P. Wendt,* Milwaukee, with *Dr. Armand J. Quick,* Milwaukee, serving as discussant. *Dr. Alwin E. Schultz,* Madison, served as a discussant on "Extended Wertheim Operation—An Obsolete Operation?," and Doctor Peckham was a discussant for "Primary Malignant Melanoma of the Vagina." Panelists on "Malignant Molar Disease" were Dr. A. Leland Kennan, Madison, and Dr. Eleanor Delfs, Milwaukee.

Physicians whose names appear in italic are members of the State Medical Society.

NEWS OF WISCONSIN PHYSICIANS

UW Chairman of Surgery

Dr. Robert C. Hickey, professor of surgery in the postgraduate school, University of Texas, was recently appointed professor of surgery in the University of Wisconsin Medical School and also chairman of the department of surgery.

In addition to his professorship in surgery at Texas, Doctor Hickey has been general surgeon and associate director for research at the M. D. Anderson Hospital, University of Texas, Houston. Born in Hallstead, Pa., he received his B.S. degree in 1938, his M.D. degree in 1942, both from Cornell University. He served three years in military service before becoming a resident in surgery at the State University of Iowa, Iowa City, Ia., where he earlier had interned.

Robert C. Hickey, M. D.

In 1947 Doctor Hickey went to the Memorial Hospital for Cancer and Allied Diseases, New York City, as assistant resident in surgery, and from 1949 to 1951 he was a trainee of the National Cancer Institute at the State University of Iowa. He became an associate in surgery and clinical assistant professor in surgery there in 1951, also serving as assistant chief of surgery in the Veterans Administration Hospital in Iowa City.

On the national level, Doctor Hickey was a consultant to the U.S. Surgeon General of the U. S. Public Health Service's Cancer Control Committee from 1959–1961. He is a member of the National Cancer Institute, and sits on the Committee on Cancer of the American College of Surgeons. He was president of the American Cancer Society, Iowa Division, from 1959–1960, and is the director and chairman of the society's research committee.

He is a member of national, state and county medical societies, American Radium Society, James Ewing Society, Society of Experimental Biology and Medicine, the Iowa Academy of Surgery, Central Surgical Association, and the New York Academy of Sciences. He is a fellow of the American College of Surgeons and a diplomate of the American Board of Surgery.

Dr. Philipp Returns to Green Bay

Dr. Louis D. Philipp, a native of Green Bay, has returned to that city after two years of practicing general surgery in Portland, Ore. He is now associated with *Dr. Leonard C. Miller*, Green Bay. Doctor Philipp received his M.D. from the University of Wisconsin Medical School in 1953; interned at Milwaukee Hospital, Milwaukee; and served with the Air Force Medical Corps for two years. He spent five years in general and vascular surgery training at Minneapolis General Hospital, University of Minnesota.

Dr. Pointer Opens Ophthalmology Practice

Dr. Robert Pointer has opened his practice in Sheboygan. He recently completed his residency in ophthalmology at University Hospitals, Madison. Doctor Pointer is a 1957 graduate of the University of Wisconsin Medical School. He interned at St. Joseph's Hospital, Marshfield, for one year before his Madison residency.

Dr. Reichle Practices in Appleton

Dr. Robert Reichle, Clintonville, has established a general practice in Appleton sharing office facilities with *Dr. Owen E. Larson*. Doctor Reichle was graduated in 1962 from Ohio State University School of Medicine. He completed his internship at St. Luke's Hospital, Duluth, Minn., in July of this year.

Attends ACS Meeting

Dr. W. L. Nelson, Wisconsin Rapids, attended the 50th anniversary meeting of the American College of Surgeons, held in San Francisco recently. Doctor Nelson has been a fellow of the American College of Surgeons since 1934, when he was named as one of the five honormen out of a class of 595 candidates, the honor ranking being based upon the quality of the candidates' reports.

Dr. Hoon Authors Article

The fall issue of the WISCONSIN CANCER BULLETIN contains an article by *Dr. J. R. Hoon*, Sheboygan, on the service committee of the American Cancer Society—Wisconsin Division. As chairman of this committee, Doctor Hoon described the function of this "action arm of the society." He recently served on the crusade committee for the annual campaign to raise funds for the cancer research program. More than $500,000 was collected in Wisconsin, and the campaign was rated highly successful.

Dr. Albright Speaks

Dr. Edwin Albright, professor of internal medicine at the University of Wisconsin Medical School,

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Preston W. Thomas, M. D.
William H. McCreary, Jr., M. D.
Adam Fueredi, M. D.
L. O. Mastalir, M. D.

Madison, discussed thyroid metabolism and disease at the October scientific meeting held in the Marshfield Clinic library. *Dr. George Magnin*, Marshfield, introduced him to the 50 local and area physicians who attended the session.

Dr. Evans Assigned to WHO

Dr. A. S. Evans, director of the State Laboratory of Hygiene, Madison, has been assigned to the World Health Organization (WHO) during June, July, and August, 1964. He will work with the Philippine Health Department.

Dr. Kalb Addresses Seminar

Dr. Clifford H. Kalb, Milwaukee allergist, addressed an Emulsion Seminar held at Lancaster, Pa., in October. The subject of his address was "Controlled Evaluation of Emulsion Treatment in Allergic Diseases."

Dr. Andrews in Scientific Unit

Dr. George R. Andrews, Wausau psychiatrist, has become a member of the Society for the Scientific Study of Sex, a national organization comprised of members from various professions. The purpose of the society is to foster interdisciplinary exchange in the field of sexual knowledge and to bring together individuals working in biological, medical, anthropological, psychological, sociological, and allied fields who are conducting sexual research.

Chemical Group Cites Dr. Quick

The Milwaukee section of the American Chemical Society presented its annual $100 award and medallion to *Dr. Armand J. Quick*, professor and chairman of the biochemistry department, Marquette University School of Medicine, Milwaukee. Doctor Quick has made fundamental discoveries about blood coagulation and is internationally recognized as an expert in hemorrhagic diseases. He plans to retire next July from Marquette, having been a faculty member since 1935 and head of the biochemistry department since 1944.

Dr. Hoessel Speaks on Rehabilitation

Dr. Arthur Hoessel, Wausau, spoke on "Rehabilitation Medicine" at the Mosinee Auxiliary of Wausau Memorial Hospital. Doctor Hoessel predicted that in the future a rehabilitation center will become as essential a department of general hospitals as the x-ray and laboratory departments.

Dr. Quinn Joins Staff of Sheboygan Clinic

Dr. Garry A. Quinn, Milwaukee, has recently become associated with the Sheboygan Clinic in the practice of obstetrics and gynecology. Doctor Quinn completed his three-year residency at St. Joseph Hospital, Milwaukee. During his tenure there he also served as assistant clinical instructor for the University of Marquette School of Medicine. His internship was served at St. Mary's Hospital, Milwaukee, from 1957 to 1958, after graduation from Marquette in 1957.

Photo courtesy of The Beaver Dam Citizen

Dr. Harold Palmer (left), Denver, Colo., president of the American Society of Clinical Pathologists, is shown above presenting an award to Dr. *William G. Richards* (center), and Dr. *Theodore Rowan*, both of Beaver Dam, at the Society's annual meeting held in October in Chicago. The two pathologists received the bronze award for their educational display "Organization of Pathology Service for a Group of Small Community Hospitals."

Dr. Glasson Joins Reedsburg Clinic

Dr. Lance G. Glasson, Tucson, Ariz., has joined the Rouse Medical Clinic in Reedsburg. Doctor Glasson spent the past year at the Veterans Administration Hospital, Tucson, as staff surgeon. He received his medical degree in June 1947 from the Marquette University School of Medicine and took his internship at Columbia Hospital, Milwaukee. He was in general practice at Tomahawk for a year before joining Columbia Hospital. In 1952 he joined the staff at Jackson Memorial Hospital, Miami, Fla., and after serving in the U. S. Army Medical Corps, Ft. Sam Houston, Tex., returned in 1955 to Jackson Hospital where in his last year there, 1958, he was chief resident in general surgery.

Dr. Vognar Joins Ft. Atkinson Clinic

Dr. Stanley Vognar, formerly of Mt. Horeb, has joined the medical practice of *Dr. Frank Gruesen* at the Gruesen Clinic, Fort Atkinson. Doctor Vognar, a native of Yugoslavia, came to the U. S. in 1958, after graduation from the University of Zagreb in Yugoslavia, and completed his internship at Edgewater Hospital, Chicago. He served as a resident in obstetrics and gynecology at Edgewater Hospital until starting in general practice in Mt. Horeb two years ago.

Medical Auxiliary Hears Dr. Gordon

Dr. Edgar Gordon, Madison, discussed "Operation Waistline" at the Dane County Medical Auxiliary luncheon in October. Doctor Gordon, a member of the University of Wisconsin Medical School, is well known for his "snack diet" featured in McCall's magazine. *Dr. Palmer Kundert*, Madison, president of the Dane County Medical Society, was the guest of honor.

Photo courtesy of the La Crosse Tribune

Dr. Robert E. Flynn, left, La Crosse general practitioner for 53 years, was honored recently at a testimonial dinner in St. Francis Hospital, La Crosse. A clock was presented to Doctor Flynn. Some 100 physicians, dentists, and others were present. Among the guests were Doctor Flynn's seven children, including the three above who are also physicians. They are, from left, Dr. Thomas E. Flynn, Sterling, Ill.; Dr. Robert A. Flynn, St. Paul, Minn.; and Dr. George F. Flynn, Milwaukee.

Dr. Grinvalsky Accepts Medical Position

Dr. Henry T. Grinvalsky, pathologist at St. Michael's Hospital, Stevens Point, has announced that he has accepted a medical school appointment at Creighton University, Omaha, Neb. Doctor Grinvalsky will become an associate professor in the pathology department at Creighton's College of Medicine.

Dr. Haugh Leaves Dousman

Dr. Thomas G. Haugh, Village of Dousman physician since September 1961, has left Dousman for Newberry, Mich., to begin practice.

Dr. Melms to Red Cedar Clinic

Dr. Frederick A. Melms, Milwaukee, has recently become associated with the Red Cedar Clinic, Menomonie. Doctor Melms received his medical training at the University of Wisconsin and the University of Michigan, graduating in June 1959. He completed his internship at Rockford Memorial Hospital, Rockford, Ill. For the past three years he served in the U. S. Air Force as a medical officer and was stationed in Germany. Doctor Melms was discharged in August this year.

Dr. Rossi Named Instructor

Dr. Ennio C. Rossi, Madison, has been appointed instructor in medicine at the Marquette University School of Medicine, Milwaukee. Doctor Rossi received his M.D. degree at the University of Wisconsin Medical School in 1954. He was a Fulbright scholar to the University of Rome, Italy, in 1955–1956. From 1958 to 1961 he was a resident in internal medicine at University Hospitals, Madison.

Dr. Stevens Named to Heart Fund

Dr. George H. Stevens, Wausau, has been named to head the 1964 Heart Fund campaign in the Wausau area. Doctor Stevens is a member of the Marathon County Heart Unit and also served as city chairman in the 1963 Heart Fund campaign.

Dr. Curreri Speaks in Stevens Point

Dr. Anthony R. Curreri, professor of surgery and director of the Division of Clinical Oncology, University of Wisconsin Medical School, spoke at the Stevens Point Area Chamber of Commerce's annual dinner meeting in October.

Dr. Schafer Speaks on Cancer

Dr. Leroy Schafer, Menasha, obstetrician and gynecologist, addressed the Twin City (Menasha–Green Bay)TOPS Club in October. His talk, on cancer, was illustrated with two films provided by the State Board of Health. They were produced by the American Cancer Society.

Attend Heart Association Meeting

Eight Wisconsin delegates attended the annual meeting and scientific sessions of the American Heart Association held in October in Los Angeles, Calif. They are: *Dr. Hugh J. McLane*, Fond du Lac; *Dr. Charles W. Crumpton*, *Dr. George G. Rowe*, and Dr. William B. Youmans, Madison; *Dr. Armin Baier*, Milwaukee; *Dr. William B. Hildebrand*, Menasha; *Dr. Francis F. Rosenbaum*, Milwaukee; and Dr. William C. Boake, Madison.

Dr. Blanchard Speaks to Young GOP's

Dr. P. B. Blanchard, Cedarburg, spoke to the Ozaukee County Young Republican Club in November. His address was entitled "Socialized Medicine is Federal Domination."

Dr. Foerster Attends Postgraduate Course

Dr. James Foerster, Wausau, attended a postgraduate course on the advances in the diagnosis and treatment of cancer at Harvard Medical School in October.

Dr. Rothe Studies in Psychiatry

Dr. Clarence Rothe, Jr. Green Bay, has begun a three-year residency in psychiatry at the Nebraska Psychiatric Institute of the University of Nebraska Medical School, Omaha, Neb. Doctor Rothe plans to resume his practice in Green Bay after he completes his residency.

Attends Psychiatric Parley

The Sheboygan County Guidance Center was represented at the November 8–9 semi-annual meeting in Madison of the Wisconsin Association of Psychiatric Clinics for Children. Those who participated were *Dr. Edward E. Houfek*, medical director of the center; and *Dr. Earl H. Jochimsen*, staff psychiatrist.

Dr. Conley Addresses Hospital Auxiliary

Dr. James E. Conley, Milwaukee, addressed the St. Mary's Hospital Auxiliary, Watertown, in October speaking on "A Decade of Progress in Cardiovascular Disease."

Heads "Aging" Talks

Dr. Adolph M. Hutter, Fond du Lac, conducted a workshop on coordinated home care programs at the 1963 state conference for the aged held in Madison, in October. In addition to serving as moderator, Doctor Hutter presented an address on concepts of medical care for the aged, and the coordinated home care program.

Dr. Madson Attends Clinical Seminar

Dr. W. L. Madson, Rhinelander, was among physicians who attended a four-day clinical seminar recently in Chicago. Lectures and panel discussions emphasized the importance of protein metabolism and its relationship to the prevention of disease.

Dr. Lofdahl Speaks on Medicare

Dr. Stewart Lofdahl, Ripon, addressed the Ripon Rotary Club in October, speaking on the King–Anderson medicare bill. He said the program would "cost $5 million the first year and rapidly skyrocket to perhaps $35 billion as more became eligible" for care.

NIH Grant to UW Research

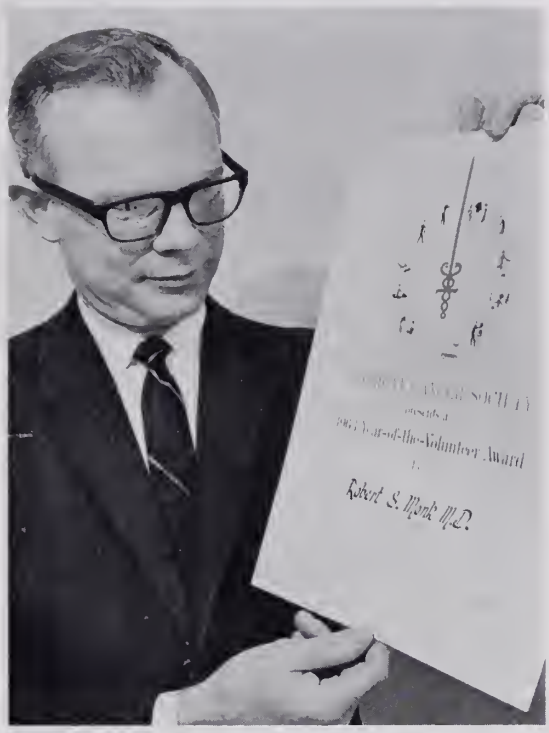
The National Institutes of Health (NIH) has awarded three grants to three University of Wisconsin Medical School, Madison, researchers. They are: Dr. Robert P. Hanson, an allergy grant of $36,840 for one year; Dr. Bernard C. Easterday, an allergy grant of $20,160 for one year; and Dr. David T. Berman, a one-year arthritis grant of $20,160.

Welfare Conference in Oconto

Representatives of 15 counties attended the Eastern Wisconsin Welfare Association conference in Oconto in October. The 110 members present heard a discussion of the Kerr-Mills medicare legislation. They were advised that although the measure is national in scope, special provisions are provided for each state. The principal speaker at the conference was Edward Lawrer, Madison, supervisor of medical service for the Division of Public Assistance. Others were Jack Blaine, who represented the State Medical Society, Madison; Elmer Harvey, Green Bay, administrator of Bellin Memorial Hospital; David Thibodeau, case worker for the Marinette County welfare department; and Norman Whitford, director of Winnebago County welfare.

Dr. McGarty to State Board of Examiners

Dr. Matt A. McGarty, La Crosse, has been appointed by Gov. John Reynolds to the Wisconsin State Board of Medical Examiners in surgery. Doctor McGarty is a past president of the La Crosse County Medical Society and past president of the State Medical Society. He also is a year around preceptor, teaching fourth-year medical students of the University of Wisconsin at La Crosse.



Dr. Robert S. Mank, Waukesha, holds up the Volunteer-of-the-Year award he received recently from the American Cancer Society. The presentation was made by the Waukesha County unit acting on behalf of the State division of the ACS. Doctor Monk was cited for carrying the story of cancer control throughout the county in various talks the past five years.

Dr. Samp Speaks

Dr. Robert J. Samp, Madison, was a visiting specialist at the regional cancer conference of the Southwest Cancer Institute in Phoenix, Ariz., recently. He discussed "Five–Fluorouracil in the Treatment of Carcinoma of the Breast." Doctor Samp also spoke recently in Dallas, Tex., to the Dallas County Medical Assistants Society on the dangers of health advertising. He also spoke to the Hales Corners Woman's Club in October on "Facts of Life for Hales Corners."

Janesville Birth Control Forum

The First Congregational Men's Club, Janesville, sponsored a birth control forum recently. *Dr. Addie Schwittay,* obstetrician and gynecologist at Jackson Clinic, Madison, presented a talk.

Health Grants

Drs. Takeru Higuchi, *Charles E. Reed,* David B. Slautterback, and Joseph O. Hirshfelder, all of the University of Wisconsin Medical School, Madison, are recent recipients of one-year National Institutes of Health grants, totaling $85,467.

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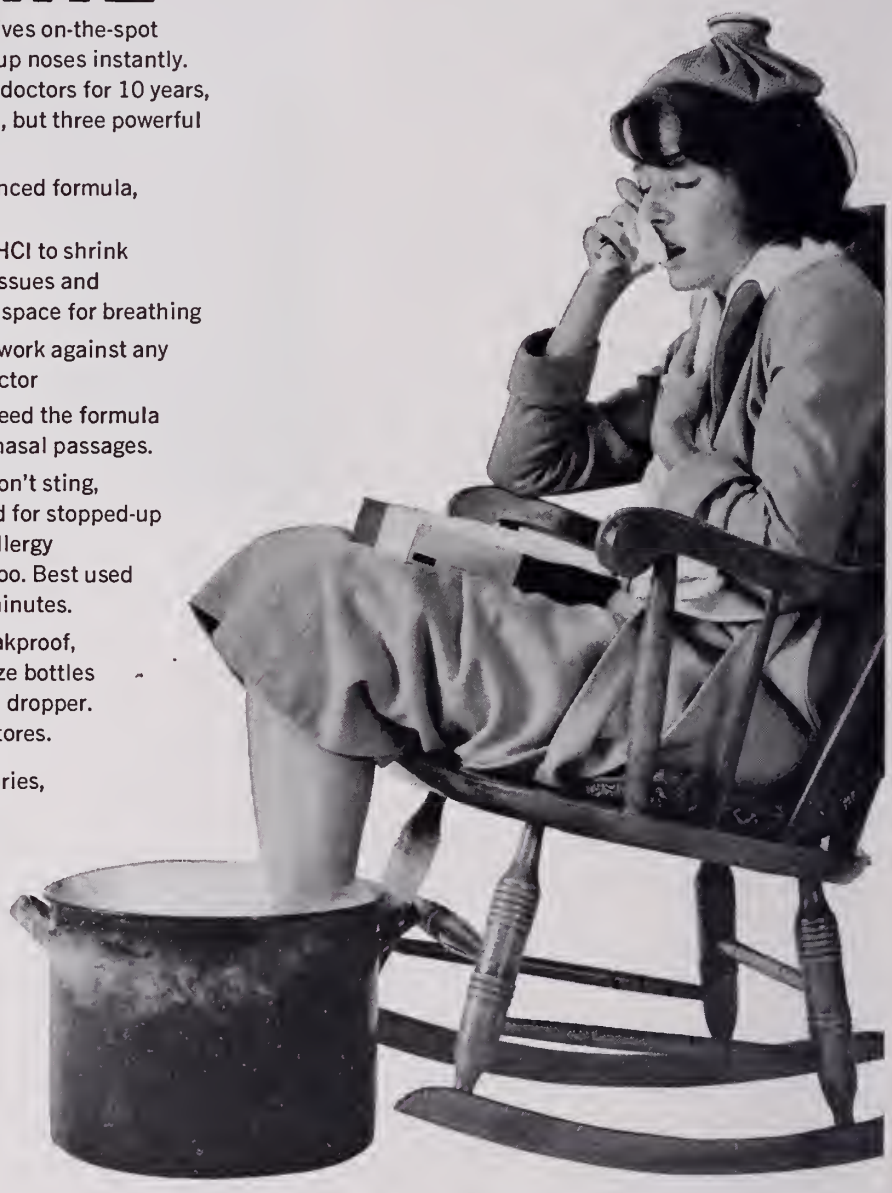

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Clinic at Grantsburg

A rheumatic fever and congenital heart disease clinic was held October 23 at Grantsburg Hospital, Grantsburg, sponsored by the Barron–Washburn–Sawyer–Burnett County Medical Society and the Wisconsin Heart Association. Dr. Robert J. Corliss, and *Dr. H. Kent Tenney*, both of Madison, examined about 25 patients who were referred to the clinic by their physicians.

Heart Talk by Dr. Lepley

Dr. Derward Lepley, Jr., associate professor of surgery at the Marquette University School of Medicine, recently discussed new developments in heart surgery at a luncheon meeting of the American Interprofessional Institute of Milwaukee.

Attends Postgraduate Course

Dr. A. O. Ashby, Sheboygan, attended a postgraduate course in obstetrics and gynecology at the University of Kansas School of Medicine, Kansas City, held for five days in October.

Attends Interstate Meeting

Dr. W. G. Huibregtse, Sheboygan, attended the Interstate Medical Convention held at the Palmer House in Chicago in October.

Silver Award for Exhibit

At the annual meeting of the American Society of Clinical Pathologists held recently in Chicago, a silver award was presented to *Drs. Edwin L. Bemis, Robert S. Haukohl*, and *Yoshiro Tairo*, of Evangelical Deaconess Hospital, Milwaukee, for their educational exhibit on "Lymphoid Cell Variations in the Peripheral Blood."

Wisconsin/Chile Exchange Program

An exchange program is now under way between departments of pediatrics at the Universities of Wisconsin, Madison, and Chile. Dr. Nathan J. Smith, chairman of the pediatrics department, University of Wisconsin, initiated the program and will travel to Santiago, Chile, next semester to conduct research on nutritional anemias.

The first exchange of teachers took place this semester with Dr. Julio Meneghello, professor of pediatrics at the University of Chile, coming to Madison for two months to study clinical cytogenetics.

The Rockefeller Foundation is providing funds for the tentative five-year program which is designed to benefit both institutions by giving faculty members a chance to use facilities not available in their homelands.

Dr. Roley Opens Offices

Dr. Everett L. Roley, Madison, has opened his practice in obstetrics and gynecologic surgery in Madison. Doctor Roley received his premedical training at St. Mary's College, Winona, Minn., and his M.D. degree at Creighton University, Omaha, Neb., with four years of special training in gynecology at the University of Wisconsin. He has practiced at the U. S. Navy Hospital, Chelsea, Mass., and in Lake Forest, Ill. Doctor Roley will also teach in the department of gynecology at the University of Wisconsin.

Dr. Wilkinson Joins Medical Group

Dr. D. E. Wilkinson, Chippewa Falls, has joined the staff of physicians at the Community Medical Group, Mondovi. Doctor Wilkinson, a specialist in surgery, is a graduate of the University of Nebraska School of Medicine. He served his internship in Illinois, and was surgical resident at the Veterans Administration Hospital, Des Moines, Ia., for four years. Other physicians associated with the Community Medical Group are *Dr. W. E. Wright* and *Dr. R. E. Reeds.*

Guest Speaker at Nursing Home

The guest speakers at the October meeting of the Sheboygan County Nursing Home Association were *Dr. Arthur C. Tompsett*, Sheboygan, president of the Sheboygan County Medical Society, and *Dr. N. Peter Braun*, Sheboygan, who discussed the King–Anderson bill.

Named University Representative

Dr. Paul C. Hodges, Jr., Appleton, has been appointed a representative of the Johns Hopkins University National Alumni Schools committee. Doctor Hodges, who received his medical degree from Johns Hopkins, is visiting local high schools for the committee.

Dr. Noer Visits Madison

Mr. and Mrs. Harold R. Noer, Madison, have sold their house to *Dr.* and *Mrs. Gerald Clinton*, and have moved to Chalet Gardens. Mr. Noer's brother, Dr. Rudolf Noer, head of the department of surgery, University of Louisville Medical School, Louisville, visited Madison at that time. The Harold Noer's son, Cmdr. Rolf Noer, is chief medical officer of the sixth Mediterranean fleet and is serving aboard the U.S.S. Little Rock. The Noers' other son, who is a director for the American Red Cross, is currently on assignment in Formosa.

Altrusans Hear Dr. Babb

Dr. John L. Babb, Beloit, was guest speaker recently at the Beloit Altrusa Club. He reviewed various angles of medical care for the aged and pointed to the dangers involved in coming under government control.

Dr. Crumpton Speaks on Heart Attacks

Janesville Rotarians in November heard *Dr. Charles W. Crumpton*, Madison, speak on "Today's Epidemic: Heart Attack—How It Affects American Businessmen." Doctor Crumpton, president of the Wisconsin Heart Association, appeared through the Association's sponsorship as part of its public education program.

· Photo by Dove Lindberg, Marshfield Clinic

The first of a monthly series of seminars for top science students in local high schools was held in October in the Marshfield Clinic, Marshfield. The speaker at this initial session was Dr. George River, Marshfield, specialist in hematology. The science discussions are sponsored by the Marshfield Clinic Foundation.

Medical Director Appointed

Dr. Ellison F. White, Harlingen, Tex., has been appointed medical director of the Southern Colony, Union Grove. Doctor White received his M.D. degree from the University of Tennessee in 1942. In addition he holds an M.S from the Minnesota Graduate School of Medicine. Doctor White interned at the Baptist Memorial Hospital, Memphis, Tenn., and completed three years fellowship in internal medicine from the Mayo Brothers Clinic, Rochester, Minn. He served as a physician on the staff of the Firland Sanitorium, Seattle, Wash., and was a medical superintendent of the Middle River Sanitorium, Hawthorne, Wis., and the Wisconsin State Sanitorium, Wales. Since 1957, Doctor White has served as chief of medicine and superintendent of the Harlingen State Tuberculosis Hospital, Harlingen, Tex.

Wisconsin ACS Fellows

Approximately 1,050 surgeons were inducted as new fellows of the American College of Surgeons (ACS) in ceremonies during the College's annual five-day Clinical Congress, held in San Francisco in October. Those receiving the distinction from Wisconsin are: *Dr. Harold T. Gross,* Appleton; *Dr. Herbert F. Sandmire,* Green Bay; *Dr. Francis R. Russo,* Janesville; Drs. Vincent L. Gott, *Donald E. Koepke, John R. Pellett, Flavio Puletti, William H. Wolberg,* all of Madison; and *Drs. William W. Baird, George M. Daley, Julian W. Falecki, Kinge Hara, Richard J. Krill, David J. McGrath, Paul Natvii, Thomas Wall, Walter J. Woloschek* and *James F. Zimmer,* all of Milwaukee.

Dr. Zach Speaks on Quackery

Dr. Robert G. Zach, Monroe, chairman of the Commission on Public Policy, spoke before the Dubuque, Ia., County Medical Society and Auxiliary in October. Approximately 90 persons attended. His talk was entitled "Iowa's Great Contribution to Quackery." Doctor Zach used a number of quackery devices, seized by the Food and Drug Administration in recent years, to illustrate his presentation.

Anesthesiologists Delegates

Three Wisconsin physicians served recently in the House of Delegates of the American Society of Anesthesiologists at its annual business and scientific meeting, in November, in Chicago. They are: *Dr. Henry J. Barina,* Racine, alternate delegate; *Dr. Robert M. Wylde,* Madison, director; and *Dr. G. M. Garnett,* Madison, delegate.

Dr. Strebe Opens Office

Dr. Kenneth Strebe, Oconto Falls, opened his new office building in Oconto Falls recently.

Dr. Meyer Speaks to Kiwanis

Dr. Thomas Meyer spoke on "The Latest Advances in Research" at a Sheboygan Lakeshore Kiwanis dinner meeting held in November at the Sky Garden Restaurant, Sheboygan.

Doctor Meyer, assistant professor of pediatrics at the University of Wisconsin Medical School, appeared through Wisconsin Heart Association sponsorship. He received his medical education at the University of Witwatersrand, South Africa; and Edinburgh University, Scotland. The author of several books and articles on pediatrics, Doctor Meyer has been a member of the Wisconsin Heart Association since 1961 and is a member of the State Physicians Speakers committee.

Dr. Shahrokh is AAOO Fellow

Dr. Darius K. Shahrokh, Fond du Lac, attended the scientific meetings of the American Academy of Ophthalmology and Otolaryngology (AAOO) held recently in New York City. He was elected a fellow of the academy. Doctor Shahrokh had his medical training in Tehran, Iran, and specialty training at the Mayo Clinic, Rochester, Minn. Before coming to Fond du Lac two years ago, he practiced for one year at the Marshfield Clinic, Marshfield.

Physicians Talk on Legislation

The 1,400 members of the Medical Society of Milwaukee County and their wives were invited to the homes of 30 physicians recently to hear talks on medical legislation affecting doctors. It is the Society's version of a national legislative plan sponsored by the American Medical Association to pre-

vent further entry of the federal government into health care. Members of the committee called "Operation Hometown," are *Dr. George E. Collentine, Jr.*, and *Dr. Benjamin Urdan*, Milwaukee.

Dr. Terner Heads Guidance Clinic

Many people would "rather be dead" than seen in a psychiatrist's office or a mental health clinic. Dr. Fred S. Terner, Green Bay, who heads the Brown County Clinic, feels that these people should be shown that their problems can be tackled and, once faced, are capable of solution. He recently presented the functions of the clinic and the role it can play in the community, pointing out that it can be a tremendous community asset. Doctor Terner, who was born in Austria, completed his medical education in Sheffield, England, and took his residency in psychiatry in Birmingham, England. He came to the U.S. in 1957 and had psychiatric residencies in Massachusetts, Connecticut, and further practice in New Jersey. He was director of a Richmond, Va., clinic before moving to Green Bay in June this year.

Grant to Milwaukee Blood Center

The Milwaukee Blood Center, Inc., Milwaukee, received $58,900 from the John A. Hartford Foundation, Inc., New York. The grant was for basic studies to enhance the safety and efficiency of transfusions and to develop an improved method for storing blood to extend the period of its therapeutic value.

Dr. Hoon Attends Meeting

Dr. J. R. Hoon, Sheboygan, attended the annual meeting of the American Cancer Society in New York City recently.

Dr. Sciarra Attends Conference

Dr. P. A. Sciarra, Sheboygan, attended the annual conference of the American Academy of Otolaryngology in New York City recently.

Dr. Duer Presents X-Ray Tubes to CES Foundation

Dr. Guy R. Duer, Winter Haven, Fla., has presented three relic x-ray tubes to the Charitable, Educational and Scientific Foundation of the State Medical Society. They will be displayed from time to time along with other memorabilia of physicians, at the Museum of Medical Progress in Prairie du Chien next year during the open season of the Museum.

The three gas tubes are quite old; one of them might date back to the late 1890's, Doctor Duer says. The roentgen ray was discovered about this time; in fact, it was in December 1895, when Wilhelm Konrad Roentgen, the German physicist, presented his famous paper on "a new kind of rays" at the Würzburg (Germany) Physical and Medical Society.

The color was in the tube after electricity was turned on showing the density or strength of the x-ray. These were later supplanted by the Coolidge tube, a highly evacuated x-ray tube with hot filament cathode and tungsten anode, invented by William David Coolidge, American physical chemist.

Doctor Duer visited the State Medical Society in August this year and made the presentation of the tubes to Dr. W. J. Egan, Milwaukee, president of the Society. Doctor Egan received them on behalf of the Museum of Medical Progress and the Stovall Hall of Health, Prairie du Chien.

Doctor Duer, now a resident of Winter Haven, Fla, is an associate member of the State Medical Society after being a regular member for many years. He retired in February 1959 after more than 36 years of practice in Marinette, Wis.

Doctor Duer first practiced in Stoughton from 1919–1923. In 1923 he took over the x-ray equipment, of which the tubes were a part, of Doctor Axtell, then of Marinette, who had been a pioneer in early x-ray work. Doctor Duer always kept complete x-ray equipment, including fluoroscopic equipment, in his office in Marinette.

Dr. G. R. Duer is shown presenting the x-ray tubes to Dr. W. J. Egon, president of the State Medical Society, who accepted them on behalf of the Museum of Medical Progress and the Stovall Holl of Health, Proirie du Chien.

During his years of practice, he served as councilor of the State Medical Society for two terms, September 1932 to September 1938, a period in which many significant events took place in the development of SMS. He has also been a member of the House of Delegates.

Doctor Duer recently completed his autobiography, which he wrote primarily for his four children. His great hobby is photography, which gives him much pleasure. He was able to indulge in much of it over the years in his many travels which have included 14 countries of Europe, Alaska, Canada, Mexico, the West Indies, South America and Hawaii. He has loaned the Society some of his pictures for display purposes.

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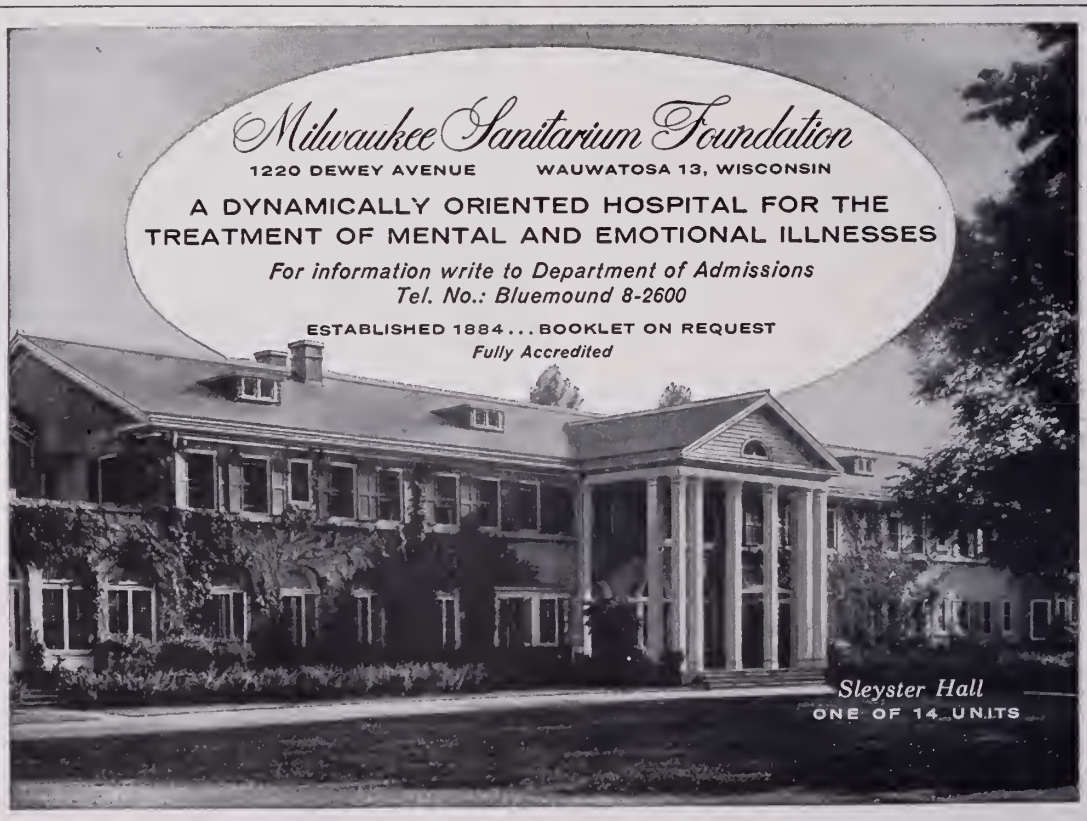


Artificial Heart Valve for Humans Developed at University of Wisconsin

The development of an artificial heart valve for humans that will function for a lifetime under the severe stresses within a heart has long been one of the goals of cardiovascular research workers throughout the world. Abnormalities of malfunctions can occur in all four of the heart's natural valves but of primary concern has been the replacement of diseased aortic and mitral valves which have resulted in thousands of deaths each year. The combined skills of a heart surgeon and a mechanical engineer have resulted in the development of an artificial heart valve which may represent a major breakthrough in heart surgery.

This new valve with a center-hinged leaflet design is the culmination of several years of intensive effort by Dr. Vincent L. Gott, Associate Professor of Surgery, University of Wisconsin Medical School, and Ronald L. Daggett, Professor of Mechanical Engineering at the University of Wisconsin, Madison. Much of their work was made possible through the financial support of the Wisconsin Heart Association and the National Institutes of Health.

Experimental

Designed to replace any of the four valves in the human heart, the new valve has been successfully implanted in a large number of experimental animals during its period of development and testing. Along with this program, extensive test programs were carried forward in flow test units, mechanical heart simulators, and fatigue testers.

Following this extensive development work, it was believed that the valve was ready to be used in the human heart and on April 30, 1963, the first valve of this design was used to replace a badly damaged aortic valve. This operation was performed at the University of Wisconsin by a surgical team headed by Dr. William P. Young, Professor of Surgery and chief of the Cardiovascular Surgery Division of the Department of Surgery. Subsequent to this date the valve has been placed in several additional patients. Three of these patients have been followed up postoperatively, and the new artificial valve appears to be functioning satisfactorily.

Structure

The housing of the Gott–Daggett valve is basically a rigid molded plastic ring containing a central cross strut and several peripheral struts to support the flexible leaflet. This housing is molded of polycarbonate plastic in three pieces which are later assembled into a completed valve. The entire housing is coated with colloidal graphite which effectively minimizes the formation of blood clots on the valve which always present a danger following surgery.

Discovery of the anticlotting properties of the graphite occurred during the development program of this new valve. The outside of the housing is covered with a new type of plastic material, Teflon felt, which is ideally suited since it is readily accepted within the heart and tissue will grow into it.

Perhaps the most difficult problem Doctor Gott and Professor Daggett encountered was the development of a satisfactory leaflet. This leaflet must be sufficiently flexible to open with a minimum pressure and, after closing must withstand very high back pressure which may range from 80 to 150 mm.

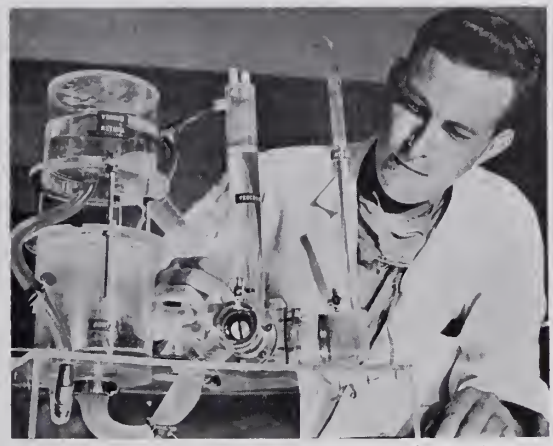


Photo by John Kreissler, Wisconsin State Journal

Dr. John Whittier, Cardiovascular Fellow at the University of Wisconsin Medical School, Madison, is shown examining the artificial heart valve developed at the University of Wisconsin.

of mercury. The opening and closing process which is repeated approximately 80 times every minute amounts to 42 million times per year.

Materials

The materials chosen for the construction of the leaflet consist of Teflon fabric and silicone rubber. The Teflon fabric is utilized for the hinged area and periphery of the leaflet and the entire fabric surface is impregnated with silicone rubber. It was found that this coating of colloidal graphite is not necessary on the leaflet since the blood flow tends to wash the leaflets, thus keeping them free from clots.

Following the succesful placement of the valve in a number of animals the unit was sent to a West Coast research laboratory and placed on a high-speed tester which simulated the demands which would be placed upon it in the human heart. The test machine opened and closed the valve 2,000 times per minute, every minute for 70 days. This was equivalent to one-quarter billion flexions in the human heart. The valve was functioning satisfactorily at the end of this period.

New Features

During the past two years a number of different valve designs have been tried by research teams around the country. The most successful of these valves has been a unit with a caged ball design. This valve has been successfully used to replace diseased mitral and aortic valves in a number of medical centers in this country. However, because of its larger size it has presented some installation problems, particularly in the aortic valve area.

The Wisconsin valve offers a number of new features which include a larger inside diameter for blood flow, a low profile (only 5/16th of an inch high), greatly reduced weight, and a leaflet that opens with a very low pressure gradient.

At the present time, the new valve is being made in six sizes and will eventually be available as a replacement for any one of the four heart valves. Doctor Gott pointed out that a number of persons at the University of Wisconsin helped in the development of the valve. These included Drs. William P. Young, James W. Whiffen, Donald E. Koepke, Richard J. Botham; and Mr. Robert C. Dutton.

OBITUARIES

Dr. Edward C. Jarvis, Tomahawk, died May 24, 1963, at the age of 49.

Doctor Jarvis was graduated from the University of Marquette Medical School, Milwaukee, in 1942. He did his internship in Jackson, Mich., and then went to Ann Arbor, Mich., for six months' of specialty work. He moved to Hillsboro, Wis., where he practiced medicine for four years, then returned to Marquette and Milwaukee County Hospital for four more years of training leading to membership in the American Board of Surgery. Doctor Jarvis, after six months training in neurologic surgery at the Crile Clinic, Cleveland, O., joined practice with Dr. Carl Fosmark, Madison, Wis.

In 1951, he joined the air force and served as a medical officer with the rank of captain at Truax Field, Madison, and Wold–Chamberlin Field, Minneapolis, Minn. After discharge, he came to Tomahawk and joined a brother, Dr. Donald F. Jarvis, in practice. The two and Dr. Harold G. Adams, now of Brandon, were associated at the Tomahawk Clinic. In January 1963, Doctor Jarvis opened a downtown office in Tomahawk. He was a member of the Lincoln County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Jarvis is survived by his wife and one daughter; his father, two brothers and one sister.

Dr. Wilbert A. Adrians, Appleton, died May 29, 1963 at the age of 56.

He had practiced medicine in Hortonville and Appleton since 1936, and formerly was chief of staff at St. Elizabeth Hospital and president of the Outagamie County Medical Society.

Doctor Adrians was a native of Green Bay; he received his BS degree from the University of Wisconsin, Madison, and his MD degree from Northwestern University School of Medicine, Evanston, Ill. He served his internship at St. Elizabeth Hospital, Appleton. He was a veteran of World War II, and served with the U. S. Navy in the South Pacific.

Doctor Adrians was a member of the American Medical Association, the State Medical Society of Wisconsin, and the Outagamie County Medical Society, and was a past president of the American Academy of General Practitioners.

Doctor Adrians is survived by his wife, Ann; a son, Father Alcuin, O.S.B.; two daughters, Joan and Susan, a postulant S.S.N.D.; and one sister.

Dr. Robert W. Kispert, Green Bay, died June 6, 1963, at the age of 71.

Born in Jefferson, he was a graduate of the University of Chicago and Rush Medical School, receiving his BS and MD degrees.

During World War I, he served as a first lieutenant in the medical corps at Base Hospital No. 7 in France. He also was a Selective Service examiner for five years.

Doctor Kispert was a member of the American Medical Association, the Brown County Medical Society, and the State Medical Society of Wisconsin. He also served as president of the Brown County Medical Society, Bellin Hospital staff, and St. Vincent Hospital staff.

He is survived by his wife, Dorothy; and one son, Robert John.

Dr. Hector C. Marsh, Shawano physician for 20 years, died June 27, 1963, at the age of 65.

Doctor Marsh was a 1938 graduate of the University of Wisconsin Medical School. He served his internship at St. Luke's Hospital, Duluth, Minn. until 1939, at which time he located at Crandon, Wis. After four years of general practice, Doctor Marsh took a one-year surgical residency at Ball Hospital, Muncie, Ind. Upon completion of this residency, he located in Shawano, and opened the Marsh Medical Clinic, which he operated until his death.

He was a member of the American College of Surgeons, the Shawano County Medical Society of which he had held the offices of president, vice-president, and secretary-treasurer; a member of the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Marsh is survived by his widow, Leone, Shawano; and two daughters.

Dr. Ulrich Senn, Milwaukee, died July 2, 1963, at the age of 80.

Doctor Senn had been engaged in an industrial practice in Milwaukee for the past 44 years. He was a 1915 graduate of Marquette University School of Medicine, and served his internship at Milwaukee Hospital. Upon completion of his residency in 1917, Doctor Senn entered military service, and was in the Medical Corps until 1919, at which time he located in Milwaukee.

He was a member of the Milwaukee Academy of Medicine, the Central Society of Industrial Medicine and Surgery, the U. S. Committee Inc. of the World Medical Association, the Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association.

Survivors are his widow, Laura, Milwaukee; and a son, Roger.

Dr. Clarence K. Schubert, Madison, died August 7, 1963, at the age of 64.

Doctor Schubert received his B.S. and M.S. degrees at the University of Wisconsin and was a 1923 graduate of Rush Medical College. He interned at the Methodist Hospital, Madison, and did postgraduate work in Berlin, Germany, and Vienna, Austria, before opening his office in Madison in 1925.

He was a member of the Academy of Ophthalmologists, past president of the Dane County Medical Society, the State Medical Society of Wisconsin, the State Medical Society of Florida, and the Ameri-

can Medical Association. Doctor Schubert was senior member and owner of the Schubert–Aageson Clinic in Madison.

Doctor Schubert was president of Clarelen Orchids, Inc., Waunakee, Wis., and developed and named many varieties of the orchid. He was a member of the Wisconsin and American orchid societies and an accredited judge and past trustee of the American Orchid Society.

Surviving are his widow, Helen; two sons, Richard and Donald, and three grandchildren, all of Fox Bluff, Waunakee, Wis.

Dr. Vincent J. Guzzetta, Milwaukee, an eye, ear, nose and throat specialist, died August 17, 1963, at the age of 57.

A native of Milwaukee, Doctor Guzzetta was a 1931 graduate of Loyola University School of Medicine, Chicago. He interned at Columbus Hospital, Chicago, and completed his residency at Tulane University, New Orleans, in 1934.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Gertrude; two daughters, Mrs. Eugene G. Gerseth, Mequon, and Miss Valeria Guzzetta, Milwaukee; a son, Vincent, Jr.; a sister, Mrs. Lester Dobbert; and three brothers, Dr. Marcus M. Guzzetta, Dr. Phillip Guzzetta, and Edward Guzzetta.

Dr. John C. Harman, La Crosse, died August 28, 1963, at the age of 65.

A native of Leon, Doctor Harman did premedical work at the University of Wisconsin and graduated from the University of Minnesota Medical School in 1931. He interned at La Crosse Lutheran Hospital and later associated with the Gundersen Clinic of that city.

He was a member of the La Crosse County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Dorothy; three sons, Peter, Paul, and Stephan; and one daughter, Ann.

Dr. David M. Daley, La Crosse, died August 30, 1963, at the age of 60.

He was graduated from the University of Minnesota Medical School in 1930, and interned at the United States Marine Hospital, San Francisco, California.

Doctor Daley was a member of the La Crosse County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Kathryn; two daughters, Mrs. John Koenig of Milwaukee, and Mrs. Thomas Arndofer of Shreveport, Louisiana.

Dr. Harry P. Maxwell, a neurosurgeon, died September 2, 1963, at the age of 46.

He was graduated from the University of Chicago Medical School in 1941 and interned at St. Luke's Hospital, Chicago, Illinois. He served his residency at St. Luke's Hospital and at Illinois Neuropsychiatric Institute.

He was certified by the American Board of Neurosurgery. He was a member of the American College of Surgeons, the Neurosurgical Society of America, the Harvey Cushing Society, and the Milwaukee Neuropsychiatric Society. Doctor Maxwell was also a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Charlotte; twin sons, John D. and Charles T.; and a daughter, Cherie.

Dr. Robert S. Vivian, retired Beloit physician, died September 2, 1963, at the age of 67.

A native of Mineral Point, Doctor Vivian graduated from Rush Medical College in 1922. He spent a year at Chicago Lying-In Hospital, after which he began practicing medicine in Beloit where he remained until 1957 when he retired and moved to Naples, Fla.

He was a past president of the Rock County Medical Society, and although he lived in Florida during his retirement, he remained a member of that society; he was also a member of the State Medical Society of Wisconsin and the American Medical Association.

He is survived by his widow, Dora; two daughters, Mrs. Paul Okey, Madison, and Dr. Virginia Vivian, Columbus, Ohio; a son, Robert, Jr., Richmond, Va.

Dr. C. T. Droege, Superior, died September 3, 1963, at the age of 77.

Doctor Droege graduated in 1916 from the Kimball Union Academy, Meridan, N.H.; attended Northwestern University from 1918–1920; and the University of Wisconsin from 1920–1922. He was a 1927 graduate of the Marquette University School of Medicine and interned at St. Mary's Hospital, Milwaukee. Doctor Droege served his residency at the Margaret Hague Maternity Hospital, Hudson County, N. J.

He was a member of the Douglas County Medical Society, serving as Medical Director of the Douglas County Hospital Sanitorium since 1942; the State Medical Society of Wisconsin; and the American Medical Association. He was also a member of the Marquette University Alumni Association. In 1961, he was named temporary City Health Officer to fill a vacancy when the Wisconsin National Guard 32nd Division was called up.

Surviving are four daughters, Mrs. Robert Kossic and Mrs. Gerald Finckler, both of Superior; Mrs. Emmett Rolson of Milwaukee, and Mrs. Kenneth Goodwin of Alexandria, Minn.; and 13 grandchildren.

Notable increase in vigor, strength and sense of well-being

OL (stanozolol-Winthrop), a heterocyclic steroid, combines nabolic effects with outstanding tolerance, stimulates appe- promotes weight gain . . . restores a positive metabolic balance. eracts the catabolic effects of concomitant corticosteroid or erapy. WINSTROL (stanozolol-Winthrop) rebuilds body tissue uilds strength, confidence and a sense of well-being in con- ssociated with excess protein breakdown, insufficient protein d inadequate nitrogen and mineral retention.

Effects and Precautions: Prolonged administration can produce utism, acne or voice change. In an occasional patient, edema observed and in young women the menstrual periods have lder and shorter. These side effects are reversible, and pa- ceiving prolonged treatment should be examined and questioned periodically so that, should side effects appear, the dosage may be reduced or administration of the drug discontinued for a time. In patients with impaired cardiac and renal function, there is the possibility of sodium and water retention. Liver function tests may reveal an increase in bromsulphalein retention, particularly in elderly patients. In such cases, therapy should be discontinued. Although it has been used in patients with cancer of the prostate, its mild androgenic activity is considered by some investigators to be a contraindication.

Dosage: Usual adult dose, 1 tablet t.i.d. before or with meals; young women, 1 tablet b.i.d.; children (school age): up to 1 tablet t.i.d.; children (pre-school age): ½ tablet b.i.d. Available as scored tablets of 2 mg. in bottles of 100. For best results, administer with a high protein diet.

WINTHROP LABORATORIES, NEW YORK 18, N. Y.

ked improvement in appetite / Measurable weight gain Winthrop

OBITUARIES *continued*

Dr. Milton Trautmann, Prairie du Sac, died September 6, 1963, at the age of 62.

Born in Lomira, Doctor Trautmann was a 1926 graduate of the University of Pennsylvania Medical School. He interned at Columbia Hospital, Milwaukee, and served his residency at Milwaukee Children's Hospital. He also graduated from Johns Hopkins School of Public Health followed by six years of service on the Wisconsin State Board of Health. He served several years with the Sauk County Red Cross.

Doctor Trautmann was a member of the Sauk County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He was always an active and enthusiastic member of the medical societies to which he belonged, and was particularly interested in the affairs of the CES Foundation of the State Medical Society, being a trustee for several years.

He is survived by his widow, Ester; four sons, Milton, Jr. of Prairie du Sac, Doctor Philip of Daharhn, Saudi Arabia, Thomas of London, England, and David at Reed College, Portland, Ore.; and a daughter, Virginia, a senior at Stout State College, Menomonie, Wis.

Dr. G. R. Reay, Onalaska, died September 9, 1963, at the age of 87.

A native of Illinois, Doctor Reay was an 1898 graduate of Rush Medical College. He practiced medicine in Iowa and Minnesota prior to moving to La Crosse, Wisconsin in 1913.

Doctor Reay was a member of the La Crosse County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

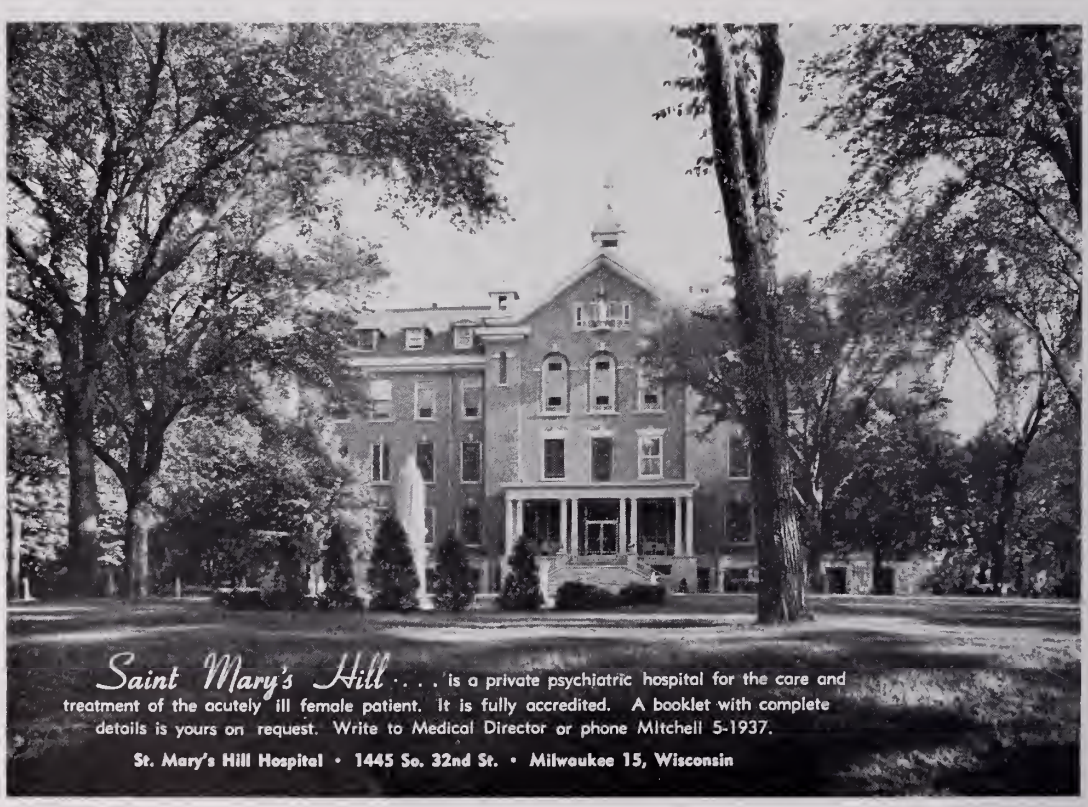
He is survived by a son, Dr. George D. Reay, formerly of La Crosse and now practicing in Scottsdale, Arizona.

Dr. Alfred L. Mayfield, Kenosha, died September 23, 1963, at the age of 72.

A native of Richland Center, Wisconsin, Doctor Mayfield was a 1917 graduate of Rush Medical College. He interned at Cincinnati General Hospital and served a fellowship in surgery at the Mayo Clinic.

Doctor Mayfield was a member of the American College of Surgeons, the Wisconsin Surgical Society, Kenosha County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Elizabeth; and a son Alfred of Platteville, Wisconsin.



MEDICAL MEETINGS

POSTGRADUATE COURSES

1964 **Wisconsin**

Jan. 18: Wisconsin State Medical Assistants Society, Fifth Annual Educational Symposium, Brooks Memorial Union, Marquette University, Milwaukee.

Jan. 29: UW/SMS "In Depth" Teaching Program on Cardiology, Room 300, Wisconsin General Hospital, 1300 University Avenue, and State Medical Society Building, Madison.

Jan. 30–31: Wisconsin Anti-Tuberculosis Assn. 1964 "Dearholt Days," Marquette University, Milwaukee (Jan. 30); University of Wisconsin, Madison (Jan. 31).

Feb. 20: UW/SMS "In Depth" Teaching Program on Orthopedics, Room 300, Wisconsin General Hospital, 1300 University Avenue, and State Medical Society Building, Madison.

Feb. 24–29: Wisconsin Work Week of Health, State Medical Society Headquarters, Madison.

Mar. 19: UW/SMS "In Depth" Teaching Program on Endocrinology, Room 300, Wisconsin General Hospital, 1300 University Avenue, and State Medical Society Building, Madison.

Apr. 2–3: Annual Meeting, Wisconsin Anti-Tuberculosis Association, Coach House Motor Inn, Milwaukee.

Apr. 4: Annual Meeting, Wisconsin Thoracic Society (WATA medical section), Coach House Motor Inn, Milwaukee.

Apr. 16–17: Institute for Hospital Administrators, Trustees, and Chiefs of Staff, Milwaukee.

Apr. 17–18: Health Fads & Fallacies Conference, State Medical Society of Wisconsin, Port Edwards.

May 11–13: Scientific program of Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

Oct. 9–10: Wisconsin Society of Internal Medicine, Annual Meeting, Delavan.

1964 **Out-of-State**

Jan. 5–8: First Annual Postgraduate Seminar in Anesthesiology, Miami Beach, Fla., sponsored by the University of Miami and University of Florida schools of medicine.

Jan. 6–10: American College of Physicians postgraduate course No. 8, "Nuclear Medicine and Radiation Biology," University of California School of Medicine, Los Angeles.

Jan. 9–11: International Symposium on Anticoagulant Therapy in Ischemic Heart Disease sponsored by Miami Heart Institute at Fontainebleau Hotel, Miami Beach. Fla.

Jan. 12–18: Tenth Annual General Practice Review, University of Colorado School of Medicine, Denver.

Jan. 13–17: Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, American College of Chest Physicians, Hotel Fontainebleau, Miami Beach.

Jan. 14–16: 13 Cardiacs, Medical College of Georgia and Foundation, Augusta, Ga.

Jan. 17–18: American Therapeutic Society and Minnesota Heart Association symposium on hypertension and coronary artery disease, Radisson Hotel, Minneapolis, Minn.

Jan. 30–31: Symposium of Scintiscanning in Clinical Medicine, Department of Radiology of Bowman Gray School of Medicine, Winston-Salem, N. C.

Jan. 30–Feb. 1: 28th Annual Session of the International Medical Assembly of Southwest Texas, Granada Hotel, San Antonio, Texas.

Feb. 2–8: Workshop in Teratology, University of Florida, Gainesville.

Feb. 7–8: Congress of the Professions. Lansing, Mich.

Feb. 17–19: Canadian-American Medical and Dental Ski Association meeting, Harbor Highlands, Harbor Springs, Mich. Sec-Treas: T. J. Trapasso, M.D., 816 Ashmun St., Sault Ste. Marie, Mich.

Mar. 1–6: American College of Allergists Graduate Instructional Course, Twentieth Annual Congress, Americana Hotel, Bal Harbour, Miami Beach, Fla.

Mar. 2–5: New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La.

Mar. 16–18, 23–25: Clinical Reviews, Mayo Clinic and Mayo Foundation, Theater, Mayo Civic Auditorium, Rochester, Minn.

Mar. 16–19: American College of Surgeons, New Orleans, La.

Mar. 16–21: Fifth postgraduate course in Medical Technology, University of Colorado School of Medicine, Denver.

Apr. 13–16: American Industrial Health Conference, Pittsburgh-Hilton Hotel, Pittsburgh, Pa.

May 5–15: Postgraduate course in "Introduction to Fundamentals of Reconstructive Surgery of the Nasal Septum and External Pyramid," University of Cincinnati College of Medicine and Christ Hospital, Cincinnati.

May 11–14: 35th Annual Scientific Meeting of the Aerospace Medical Association, Americana Hotel, Miami Beach, Fla.

June 1–5: American College of Physicians postgraduate course No. 17, "Recent Advances in Clinical Nutrition," Lemuel Shattuck Hospital, Boston, Mass.

June 8–12: American College of Physicians postgraduate course No 18, "Recent Progress in Endocrinology," University of Washington School of Medicine, Seattle.

June 15–19: Postgraduate course in psychiatry for internists, American College of Physicians, Psychiatric Institute and General Hospital, University of Maryland School of Medicine.

May 11–14: Annual scientific meeting, Aerospace Medical Association, Americana Hotel, Bal Harbour, Miami, Fla.

May 25–27: Annual meeting, American Thoracic Society, medical section of the National Tuberculosis Association, New York City.

June 15–19: Postgraduate course in Psychiatry for Internists, sponsored by the American College of Physicians, at Psychiatric Institute and the General Hospital of the University of Maryland School of Medicine.

Oct. 11–15: Eighth International Congress on Diseases of the Chest, Council on International Affairs of the American College of Chest Physicians, Mexico City, Mexico.

W. B. SAUNDERS COMPANY

features the following new editions in their full page advertisement appearing elsewhere in this issue:

ATOMIC ENERGY ENCYCLOPEDIA OF THE LIFE SCIENCES—Edited by C. W. Shilling. A unique new volume for those seeking general information on applications and effects of atomic energy in the fields of medicine, biology and agriculture.

CURRENT PEDIATRIC THERAPY—Edited by Gellis and Kagan. This new book gives you the best treatments, currently in use by leading authorities, for over 300 diseases and disorders that afflict children.

UW/SMS Teaching Program on Cardiology

The third in a series of five University of Wisconsin Medical School and State Medical Society "in-depth" teaching programs will be presented on January 29, 1964, with its topic being "The Ailing Heart." Various aspects of heart failure will be covered, and efforts will be made to relate the discussion to practical applications of diagnosis and therapy which will be of special value to the family physician.

A "wet clinic" type presentation will be utilized during the two hours of morning instruction, 10:00 a.m. to 12 n., at Wisconsin General Hospital, room 300, 1300 University Avenue, Madison. Cases applicable to the following subjects will be presented for discussion: hemodynamic aspects of congestive heart failure, the kidney in congestive heart failure, unusual causes of heart failure, a clinical consideration of cor pulmonale, pediatric aspects of congestive heart failure, and congestive phenomena occurring in pregnant women with heart disease.

The afternoon program which will be held at the State Medical Society Building, 330 E. Lakeside, Madison, from 12 n. to 4:00 p.m., including lunch, will feature "Diuretic Therapy" presented by Dr. Walter Kirkendall, Professor of Medicine, State University of Iowa College of Medicine, Iowa City, Ia. Also to be presented will be "Clinical Management of Congestive Heart Failure," by *Dr. Charles W. Crumpton*, Professor of Medicine, University of Wisconsin; and "Cardiovascular Surgery in the Control of Congestive Heart Failure," by *Drs. George G. Rowe*, Associate Professor of Medicine, and *William P. Young*, Associate Professor of Surgery, University of Wisconsin.

ACOP Course in Nuclear Medicine and Radiation Biology

The American College of Physicians Postgraduate Course No. 8 on "Nuclear Medicine and Radiation Biology" will be held Jan. 6 to 10, 1964, at the University of California School of Medicine, Los Angeles, in the Laboratory of Nuclear Medicine and Radiation Biology Auditorium, 900 Veteran Ave., Los Angeles.

The course is designed to inform the internist of the contributions that nuclear medicine can make to patient care and to acquaint him with the somatic and genetic effects of ionizing radiation on living organisms, including man. Major emphasis will be placed on an assessment of the value and effectiveness of diagnostic and therapeutic nuclear medical procedures in the clinical management of patients.

Registration forms and requests for information should be directed to: Edward C. Rosenow, Jr., M.D., Executive Director, The American College of Physicians, 4200 Pine Street, Philadelphia 4 Pa.

Announcing THE TWENTY-SEVENTH ANNUAL MEETING OF

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters—Roosevelt Hotel—March 2, 3, 4, 5, 1964

GUEST SPEAKERS

Nicholas M. Greene, M. D., New Haven, Conn.
ANESTHESIOLOGY

Adolph Rostenberg, Jr., M. D., Chicago, Ill.
DERMATOLOGY

Arthur P. Klotz, M. D., Kansas City, Kans.
GASTROENTEROLOGY

J. Roswell Gallagher, M. D., Boston, Mass.
GENERAL PRACTICE

Roger B Scott, M. D., Cleveland, Ohio
GYNECOLOGY

George R. Herrmann, M. D., Galveston, Tex.
INTERNAL MEDICINE

William C. Thomas, Jr., M. D, Gainesville, Fla.
INTERNAL MEDICINE

John B. Reckless, M. D., Durham, N. C.
NEUROPSYCHIATRY

Robert A. Cosgrove, M. D., Jersey City, N. J.
OBSTETRICS

Roy O. Scholz, M. D., Baltimore, Md.
OPHTHALMOLOGY

Otto E Aufranc, M. D., Boston, Mass.
ORTHOPEDIC SURGERY

Paul H. Holinger, M D., Chicago. Ill.
OTOLARYNGOLOGY

Paul K. Lund, M. D., Seattle, Wash.
PATHOLOGY

Margaret Lyman, M. D., New York, N. Y.
PEDIATRICS

David S. Carroll, M. D., Memphis, Tenn.
RADIOLOGY

C. Barber Mueller, M. D., Syracuse, N. Y.
SURGERY

Lloyd M. Nyhus, M. D., Seattle, Wash.
SURGERY

John K. Lattimer, M. D., New York, N. Y.
UROLOGY

The Lawson Memorial Lecture
Isidor S. Ravdin, M. D., Philadelphia, Pennsylvania

Lectures, symposia, clinicopathologic conferences, round-table luncheons, medical motion pictures, technical exhibits and entertainment for visiting wives.

(All-inclusive registration fee—$20.00)

THE CLINICAL TOUR TO EUROPE VISITING LISBON, MADRID, ROME, VIENNA, BERLIN, AND PARIS
Leaving March 7 via air and returning March 28, 1964

For information concerning the Assembly meeting and tour write
Secretary, N. O. Graduate Medical Assembly, 1430 Tulane Avenue, New Orleans, La. 70112

"Dearholt Days"

Dr. Averill A. Liebow, one of the nation's leading medical scientists in the field of pathology and a professor at Yale University School of Medicine, will deliver the main address at the Wisconsin Anti-Tuberculosis Association's 1964 "Dearholt Days."

The program is scheduled for January 30 at Marquette University in Milwaukee and January 31 at the University of Wisconsin in Madison.

In recent years, Doctor Liebow has been investigating cardiopulmonary diseases. He received a Guggenheim Fellowship to further his research in 1957.

Doctor Liebow served on the joint commission for investigation of medical effects of the atomic bomb in 1945 and 1946 and is chairman of the committee on pathology of the National Research Council.

Medical College of Georgia

The Medical College of Georgia and Foundation will present "13 Cardiacs," January 14–16. Participants and faculty will be sent 13 case histories complete with x-ray, ECG, and other data. A cardiologist, assigned to each case, will defend his diagnosis and management against any dissenting opinion. "Answers" will then be demonstrated in the form of autopsy material, physiological data, or medical and surgical therapeutic results.

Registration is limited to a small group for close participant-faculty communication. The fee of $50.00 is payable at the time of application. Fee includes dinner on January 14. The course is acceptable for 18 hours credit, Category I, by the American Academy of General Practice. Write to: Dr. Claude-Starr Wright, Director, Department of Continuing Education, Medical College of Georgia, Augusta, Ga. 30902.

Hypertension/Coronary Artery Symposium

Hypertension and coronary artery disease will be the subject of a two-day symposium, Jan. 17 and 18, 1964, at the Radisson Hotel, Minneapolis, Minn. The program will be cosponsored by the American Therapeutic Society and the Minnesota Heart Association.

Main emphasis of the sessions, to which all midwest physicians will be invited, will be the therapeutic aspects of the two health problems. Those attending will have the opportunity to question nationally known authorities and to discuss their own experiences in the clinical management of the diseases. The program will be keyed to the significant interests of both general practitioners and specialists.

Nine hours of American Academy of General Practice Category II credit have been authorized for attendance at the symposium.

Arrangements have been made to make available a special block of tickets to the Minneapolis performance of the Broadway success, "Who's Afraid of Virginia Woolf," the evening of January 17. In addition, special events are being planned for the entertainment of wives of the attendees.

New Orleans Graduate Medical Assembly

The twenty-seventh annual meeting of the New Orleans Graduate Medical Assembly will be held March 2, 3, 4, and 5, 1964, with headquarters at the Roosevelt Hotel, New Orleans, La.

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include 55 informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, medical motion pictures, round-table luncheons and technical exhibits.

Following the meeting in New Orleans, arrangements have been made for a clinical tour to Europe leaving via air on March 7. The itinerary includes visits to Lisbon, Madrid, Rome, Vienna, Berlin, and Paris, returning on March 28.

Details of the New Orleans meeting and the tour are available at the office of the Assembly, 1430 Tulane Avenue, New Orleans, La. 70112.

WISCONSIN STATE MEDICAL ASSISTANTS SOCIETY

Fifth Annual Educational Symposium

Brooks Memorial Union—
Marquette University

620 North 14th St., Milwaukee, Wisconsin

JANUARY 18, 1964

8:00	REGISTRATION
9:00	WELCOME *Miss Edith C. Murphy*, President, WSMAS *William J. Egan, M.D.*, President, State Medical Society
9:15	MEDICAL TERMINOLOGY *Elizabeth Regan, R.N.* Assistant Professor of Nursing University of Wisconsin
10:00	Coffee Break
10:20	ANATOMY *Mary Vick, R.N.* Milwaukee Institute of Technology
12:00	Luncheon and Guest Speaker
1:30	YOUR CHAPTER'S HEALTH—PROLIFIC OR PARALYTIC? *William D. Coder, Ph.D.* Director of Conferences and Institutes University of Iowa
2:15	ROUND TABLE DISCUSSIONS Oral Communications—Written Communications—Collections—Insurance—Laboratory Procedures—Medical Assisting
3:00	SUMMARIES BY MODERATORS
3:30	AWARDING OF DOOR PRIZES

All medical assistants throughout the state are invited to attend. Membership in the society is not required.

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

March 2, 3, 4 and 5, 1964

Palmer House, Chicago

Panels on Timely Topics
Teaching Demonstrations
Medical Color Telecasts
Instructional Courses
Film Lectures

The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservations at the Palmer House.

Coca-Cola, too, is compatible with a well-balanced menu. As a pure, wholesome drink, it provides a bit of quick energy..brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE-MARK ®

Classified Advertisements

Advertisements in this section are accepted in two categories: PHYSICIANS' EXCHANGE and COMMERCIAL.

RATES: 10¢ per word, with a minimum charge of $4.00 per ad. Additional insertions of same ad at one-half price each, maximum time one year. Display: $10.00 per column inch.

DEADLINE: Copy must be received by the 15th of the month preceding month of issue. Send copy to: Wiscansin Medical Journal, Box 1109, Madison 1, Wis.; or phone Alpine 6–3101.

PHYSICIANS' EXCHANGE: This section is limited to physicians and others desiring physician placement, sale of medical practice or equipment of a physician, sale or lease of medical buildings, etc. Advertisements from individual members of the State Medical Society of Wisconsin are accepted without charge. Widows of deceased member physicians are allowed to advertise without charge. The rates quoted above apply to ads placed by clinics and others. There is no additional charge far ads with Dept. numbers. For these ads, address replies to: Dept. ___, % Wisconsin Medical Journal, Box 1109, Madison 1, Wis. Advertisers using Dept. numbers forbid the disclosure of their identity. All inquiries are forwarded to them immediately.

COMMERCIAL: Advertisements are accepted at the above rates from individuals, firms, organizations, etc., who are reputable, have a good credit rating and advertise products or services of ethical standards. The Journal reserves the right to reject any advertising. Advertisements from member physicians are also accepted at the above rates.

PHYSICIANS' EXCHANGE

FOR SALE: GENERAL PRACTICE in industrial city of approximately 50,000 in central Wisconsin. Fully staffed, fully manned 275-bed open staff hospital. Good recreational facilities. Should gross $35,000 the first year. Contact Dept. 64 in care of the Journal. m8tfn

FOR SALE: GENERAL PRACTICE. In beautiful northeastern Wisconsin where two doctors are covering potential of 10,000 people. Drastic need of a doctor, preferably two, to take over the practice of deceased physician. Office has large waiting room, two consultation rooms, examining room, two treatment rooms, laboratory, and library. A pharmacy is adjacent to the building. Equipment of the highest quality and TRAINED PERSONNEL ready to help you. Good hospital in town. Practice has great surgery potential. Townspeople will help you if you are the right person. Contact Mrs. H. A. Aageson, Oconto, Wis. Please supply references with your reply. m9–11

WANTED: GENERAL PRACTITIONER for association with two-man group located near Madison. Excellent hospital and recreational facilities. Salary open to start with partnership opportunity at end of one year. New building with excellent equipment and personnel. Contact Dept. 52 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER as associate. Immediately available opportunity to practice in well established group of two. Replacement for sudden loss of partner. Eventual partnership. 126 E. Main Street, Madison. AL 6–3171. m9tfn

WANTED: GENERAL PRACTITIONER as a replacement in town of 1,275 in southern Wisconsin. Gross receipts $42,000 in 1961, over $24,000 first 6 months 1962. Unopposed, good schools, churches, roads, fishing. Nearby accredited 200 bed hospital. Leaving for residency. Contact: D. L. Minter, M.D., Clinton, Wis. m9tfn

OFFICE SPACE for two or three physicians, OB or two surgeons. To rent or to sell. Pharmacy in same building. Contact Dept. 33 in care of the Journal. m3tfn

RADIOLOGY PRACTICE WANTED: Would like to serve several small hospitals or clinics. Contact Dept. 74 in care of the Journal. m12tfn

SMALL GROUP NEEDS general practitioner, preferably recent graduate with military obligation fulfilled. New clinic fully equipped; hospital, 1 block; 50 miles north of Milwaukee; no investment needed; top remuneration. Contact L. J. Steffan, M.D., Plymouth Clinic, Plymouth, Wis. m12tfn

FOR RENT: Physician's office, established location in Elm Grove, ground floor, 2 treatment rooms, private office, laboratory, x-ray room, built-in reception office and waiting room, private lavatory; good parking facilities; general practitioner preferred. Call J. R. Viele, D.D.S.—SU 2–5400; or Howard Halaska—SU 2–5700, Elm Grove, Wis. 12tfn

PARTNER IN GENERAL PRACTICE WANTED in Green Lake county, town of 5,000. Fifty-bed private hospital Five grade schools and one high school. No predominant nationalities. Various churches. Main occupations are leather, fur and metal. Contact Dept. 20 in care of the Journal. m11tfn

STOPPED MEDICAL PRACTICE, ill health. For sale: Burdick EKG; high speed centrifuge, hematocrit centrifuge; steel office furniture, all new since 1957; office instruments; one repaired Hamilton table and cabinet; one new Hamilton cabinet; steel shelving etc.; and hydraulic table. John A. Booher, M.D., Reedsburg. m9tfn

EXCELLENT OPPORTUNITY for PSYCHIATRIST or physician interested in psychiatry to become associated with Mendota Hospital medical team. Permanent Civil Service position with associated benefits. Salary $1,000 and upward per month, depending upon experience and training. Housing available at nominal charge. Regular work hours. Staffed by about 30 psychiatrists and/or physicians. Investigate now. W. J. Urben, Superintendent, Mendota State Hospital, Madison 4, Wis. g9tfn

FOR RENT NOV. 1: Approximately 1,000 sq. ft. office space, ground floor, at 304 N.E. Avenue, Waukesha. Ward Evenson, D.D.S., 306 N.E. Avenue, Waukesha, phone LIberty 7–8000. 10tfn

WANTED: YOUNG GENERAL PRACTITIONER who is interested in general medicine and obstetrics to associate with a small group in northwestern Wisconsin. Salary arrangements to start with early partnership. Contact Dept. 70 in care of the Journal. 10tfn

FOR SALE: Good working older type x-ray machine with fluoroscopic attachment. Takes excellent bone pictures. Price $200. D. J. Sievers, M.D., 118 Spring St., Berlin, Wis. m10–12

WANTED: PHYSICIAN. Capable general practitioner preferred. Challenging assignment, affording opportunity to fully utilize talents and knowledge. Chance to enjoy normal life. Unusual fringe benefits. Contact Chief of Staff, Veterans Administration Center, Wood (Milwaukee), Wis. Telephone EVergreen 4–2000, Extension 250. 10–12

RESIDENCIES in Physical Medicine and Rehabilitation offer ideal opportunity in a growing field to the general practitioner who has decided to specialize. Comprehensive training utilizing Mayo Clinic facilities and faculty, at $3,600 to $8,000 stipend. Attractive community with excellent school system and cultural advantages. Contact E. C. Elkins, M.D., Mayo Foundation, Rochester, Minn. p10–12

FOR SALE: One large scale, one microscope, two OB forceps, one instrument case including many surgical instruments. Any at half-price or all for $150.00. William Lumsden, M.D., Route 4, Menomonie, Wis. m12tfn

WANTED: Physician for LOCUM TENENS, six to eight weeks starting Jan. 15 if possible. City of approx. 50,000. Fully staffed 275-bed hospital. Excellent recreational area. Office fully equipped. Will make excellent financial arrangement. Contact Dept. 78 in care of the Journal. m12–1

FOUR-ROOM SUITE plus use of large, pleasant waiting room available in air-conditioned, modern allergy clinic. ENT or medical man (GP?)-(Pediatrician?) would find space unusually advantageous. Adjacent Capitol Court Shopping Center, northwest Milwaukee area. Contact Dept. 67 in care of the Journal. m9tfn

OFFICE SPACE in medical clinic, 2218 North Third Street, Milwaukee, Wis.; Co. 4–2800. m3tfn

WANTED: GENERAL PRACTITIONER for associate with two other general practitioners in community of 2,400 with trade area of 7,000 in Green county. No investment required. Excellent clinical and diagnostic facilities. 200 bed hospital 15 miles. Good educational facilities. Convenient communications to recreational areas. Contact M. W. Stuessy, M.D., Brodhead. m3tfn

GENERAL PRACTICE available immediately in Milwaukee, Wis. (southeast side). Established 35 years, busy active practice, excellent location, beautiful ground floor clinic building, air-conditioned. Contact Dept. 41 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER. Must be graduate of class A medical school, preferably with two-year internship from class A teaching hospital. Midwest industrial city of 46,000. Open staffed, fully equipped, 250-bed hospital. Equal partnership if satisfactory within two years. Excellent recreational facilities. Have well established general practice. Contact Dept. 57 in care of the Journal. m5tfn

WANTED: GENERAL SURGEON, well qualified, to join two man clinic group in community of 40,000. Excellent facilities and limitless opportunity. State qualifications and availability when contacting Dept. 61 in care of the Journal. m7tfn

WANTED: PSYCHIATRIST. County community 80,000. Two and one-half days per week at mental health center and county mental hospital. $16,000 annually. Administrator, Mental Health Center, 339 Reed Ave., Manitowoc, Wis. 11–12

WANTED: Young general practitioner for association with 32-year-old established general practitioner. American graduate. Military obligation satisfied. Early partnership. City of 70,000, in the southeast corner of the state. Two large open staff hospitals. Contact Dept. 73 in care of the Journal. m11tfn

WANTED: A two man partnership would like a general practitioner interested in internal medicine or an internal medicine man to become associated. Location is in north central Wisconsin. New hospital facilities are available as well as a large extensively equipped office. Contact Dept. 59 in care of the Journal. m7tfn

GENERAL PRACTITIONER for psychiatric treatment center. Excellent working conditions. Starting pay from $12,000 to $15,600 based on experience and training. State Civil Service status with associated benefits. Forty-hour week, paid holidays, vacation, retirement fund. Some on grounds housing for single, or small families. Hospital location on beautiful 300-acre Lake Mendota frontage site. Contact Dr. W. J. Urben, Superintendent, Mendota State Hospital, Madison 4, Wis. g9tfn

FOR SALE: The following equipment has been used and is all in good working condition: Castle sterilizer, 4x6x16", on stand. Cameron electrical surgical unit and electrodes, on stand. Electric headlights, many vaginal speculi, all sizes. Any reasonable offer will be considered. E. G. Welke, M.D., 1310 Morrison, Madison, Wis. Telephone ALpine 6–7606. m10tfn

FOR SALE: Equipment of retiring physician, including National cautery; 15 MA-120KV Profexray machine with table and accessories; Birtcher Crystal Bandmaster diathermy with surgical attachments; cold quartz ultraviolet light; various small instruments and treatment room supplies. Contact Mr. Harvey Schellpfeffer, 44 N. Main St., Mayville, Wis., Telephone 8. m11tfn

FOR SALE: Air-conditioned first floor office building, 1800 sq. ft., supplemental rental income from three dental offices upstairs. Owner in practice 13 years before leaving, had large, active practice. In city of Mayville, Wis., near Horicon marsh recreational area, state's largest cities for cultural, shopping activities. Open staff hospitals nearby. Contact Mr. Earl Anderson, 607 Seitz Ave., Mayville, Wis. m7tfn

HEALTH COORDINATOR, Village of Shorewood: Supervisor of public health staff consisting of professional and clerical employees for health program for community and schools. Graduation from accredited school of nursing, supplemented by bachelor's degree required. Master's degree in public health or master's degree with nursing major in supervision, teaching, or administration preferred. Salary open. Civil service status. Applications may be obtained at the office of the Village Manager, 3930 North Murray Ave., Shorewood, Wis. 53211 12

FOREIGN MEDICAL GRADUATE wishes to take two-year preceptorship in general surgery with certified surgeon. Have Wisconsin license; three years approved training. Contact Dept. 75 in care of the Journal. m12tfn

FOR SALE: 15 milliampere portable Westinghouse x-ray machine complete with cassettes, film holders, and three-drawer metal storage file; reasonable offer acceptable. Contact Dept. 76 in care of the Journal. m12tfn

FOR SALE: Norelco dictating machine, pediatric table, examining table, biological refrigerator, treatment tables, office scales, and centrifuge. Contact Clarence Rothe, M.D., 2573 Oakwood Ave., Green Bay, Wis. m12-1

FOR SALE: GENERAL PRACTICE in Prairie du Sac, Wis.; well established, same location for 15 years in fully equipped 4 room suite of offices, including small unit x-ray machine; ground floor clinic building, balance of space rented to dentist. Same office help for 15 years. Hospital facilities available in community, a rural village 27 miles northwest of Madison. New school, swimming pool and housing available. Office building and equipment may be purchased or rented. Practice available because of recent death of Milton Trautmann, M.D. Contact Mrs. Esther F. Trautmann, Prairie du Sac, Wis., or Attorney R. F. Cuftin, Box 36, Sauk City, Wis. m9tfn

WANTED: PEDIATRICIAN for two-man department in 13-man multi-specialty group located in southern Wisconsin city of 37,000. Salary first two years, then share in profit. Excellent retirement and vacation policy. Contact Dept. 58 in care of the Journal. 6–11

WANTED: GENERAL PRACTITIONER or man with specialty who will do general practice and associate with one or two other men in well established practice. Fox River Valley. Immediate opening. Community of 50,000. Salary two years, then partnership. Contact Dept. 38 in care of the Journal. m4–5

URGENTLY NEEDED: General Practitioner to become associated with small clinic group in Milwaukee, Wis., preferably one who has had practical experience and a special interest in obstetrics or industrial surgery. First year, salary; then profit percentage leading to partnership. Contact Dept. 48 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER to replace retired physician in established three-man group. Must be interested in general medicine, obstetrics, and willing to assist in surgery. Fully equipped medical suite including x-ray and laboratory in town of 50,000 in Fox River Valley of Wisconsin. Unusual opportunity with eventual partnership. Contact Dept. 36 in care of the Journal. m3tfn

WANTED: PHYSICIAN to associate with two established general practitioners in southeastern Wisconsin industrial, agricultural community of 6,000. Prefer one who has had special surgical or obstetrical training and willing to do general practice along with surgery or obstetrics. Contact Dept. 31 in care of the Journal. m1–3tfn

WANTED: GENERAL PRACTITIONER to become associated with small group in central Wisconsin, preferably one who has had some practical experience, and has a special interest in obstetrics; also willing to only assist in surgery. Contact Dept. 969 in care of the Journal. m2tfn

Physician and Hospital Records Retention and Inspection

IT IS AGREED that ownership of medical and hospital records rests, respectively, with the physician and the hospital. The doctor-patient-hospital relationship has been considered by the legislature. They have declared it to be in the public interest that the patient have right to access to relevant records concerning his medical care and treatment.

Because physicians, patients, hospital personnel and others are not always clear as to their respective rights and obligations, and because there is uncertainty as to what constitutes the "hospital record", representatives of the State Medical Society of Wisconsin and the Wisconsin Hospital Association have jointly undertaken an Interpretation of this subject. It contains recommendations and suggestions regarding hospitals' and physicians' responsibilities under Section 269.57 (4) which was enacted as part of Chapter 301, Laws of Wisconsin, 1959.

The Interpretation approved by the Council of the State Medical Society and the Board of Trustees of the Wisconsin Hospital Association is printed in full immediately following this article.

Since a patient does have a right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

Patients generally are classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 21 who are mentally competent; (2) over 21 who are mentally ill; and (3) under 21.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, one of the hospital's employees, or a member of the hospital's or clinic's medical staff.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not of legal considerations.
2. A patient of legal age has three years within which to sue for personal injuries. He may have up to 20 years to sue on a contract. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least three years. We are unaware of any *legal* requirement for accommodating a former patient longer than the suggested three years, although there are doubtless sound professional reasons for retaining them longer.
3. The period recommended for retention of records to defend against an allegation by a former patient of negligence would depend upon the category in which the patient fell. If the patient is over 21 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within three years after the alleged act. If the patient is over 21 and mentally ill at the time of his treatment or hospitalization, or becomes so within three years thereafter, suit must be brought on his behalf, or by him if he recovers, within a maximum of eight years. If the patient is a sane minor at the time of the treatment or hospitalization, he must sue for the alleged negligence by the time he reaches 22, unless his guardian did so before he became of age.
4. To the extent that patients' records are retained to assist in collection of accounts, such claim must be enforced within six years of the time it was incurred, unless such time was extended by act of the person owing the account.

It should be mentioned here that an accurate and durable reproduction of the record on microfilm or similar process is as fully admissible before a court as the original itself. Therefore, the originals of your records, once they are microfilmed, may be destroyed. However, it is advisable to keep

the original record for at least three years or until the patient has paid your bill. The reasons for this recommendation are, first, the original is in many ways more convenient to handle and to read than microfilm; second, the opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

The allegation that something is missing from the record could be of great importance when the patient is suing for alleged negligence on the part of the physician or hospital. Since the patient does have a right of access to the use of relevant records which concern his care and treatment, it would appear to be advisable to keep the originals for at least the three-year period.

If you receive a request for examination and copying of records, it probably will not state what specific records are needed. Your records may go back for 20 years or more.

Before complying with the request of a patient to examine and copy his records, it is suggested that the physician confer, if practical, with the patient to ascertain *why* he needs his records copied for such a long period of time. If by any chance the records contain material relating to conditions which would be embarrassing to him, or which might involve other members of his immediate family, he might be very grateful to have the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records for such a long period. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any of such parties.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. Further, the physician or hospital should *not* permit anyone outside the staff to copy the record except in the presence of a staff member. Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Some physicians are requesting not only that the time periods to be copied from a medical record be specified but also that each particular illness be specified in the authorization from the patient.

A number of other precautions are indicated in the Interpretation of Chapter 301, Laws of 1959, which follows. The physician or anyone designated to handle this matter would do well to review the contents of the Interpretation *before* interviewing the patient or preparing such parts of the medical record as the physician concludes to furnish.

Needless to say, the physician should not proceed under any circumstances without a *written* authorization signed by the patient; and the physician should be satisfied (1) that the signature is the patient's, (2) that he is mentally competent to make the request, and (3) that the information is not of the character which would be likely to cause him nervous or other damage. While it is true the patient has what looks like a rather direct and simple legal right, the fact also remains, as to any specific care and treatment furnished by the physician, that the latter has a continuing responsibility toward him for such care and treatment.

Since no wording appears in the statutes prescribing the form of authorization to inspect and copy a patient's record, a model form is not being recommended. However, as a suggested guide for hospitals and physicians, there are sample forms included in the Interpretation which follows. They are not to be construed as model authorization forms, but merely as suggested guides.

An Interpretation of Chapter 301; Laws of 1959

1. Upon being presented with an authorization form for the inspection of medical records, physicians and hospitals must assure themselves that the patient did *in fact* sign the authorization, and that he was of *legal age* and had the *mental capacity* to know what he was signing. A minor or incompetent must act through his guardian, and the hospital or physician must take such precautions as are necessary to satisfy themselves that those signing are thereby authorized to effect the release of the records of the patient.

The hospital or physician must be assured that the *person presenting* the authorization to inspect or copy records is the *identical person named* in such instrument. So long as there is any prudent or reasonable doubt as to the identity of a person presenting authorization to inspect or copy records, the hospital administrator, or his representative, or the physician, depending upon which place the authorization is presented, is warranted in refusing to honor such authorization. The same is true if there is any substantial question as to the mental capacity of the patient or as to the authenticity of his signature.

On being satisfied that the authorization presented is properly signed, as previously outlined, and that the person presenting it is the person named therein, and that no question of mental capacity or of minority is involved, it then becomes the duty of the hospital, institution or physician to permit such person to inspect and copy "medical or hospital reports, photographs, records, papers and writings" concerning the care and treatment of such patient.

It is first necessary to determine what must be made available for inspection and/or copying. It is

believed that under a strict interpretation of subsection (4) of the statute, the physician's records (office or hospital), and the hospital clinical record or chart should be presented. In the case of x-rays there seems to be some disagreement among legal authorities that they are part of the medical record as such or are technically photographs. It is advised that x-rays *not* be released unless by court order, and that they be inspected *only* under proper supervision (in the case of a hospital or other institution by a qualified physician, or in the event of his unavailability, by a person designated by the administrator; in the case of a physician's office, by the physician in charge, an associate, or the designee of either).

Administrators and physicians should be cautioned that the copies of the records should be made only under properly authorized supervision, and that the originals of the records cannot be taken out of their custody at any time *except* under court order.

To avoid substantial wasted administrative or professional time with the examination and copying of records relating to illnesses which do not fall within the inquiry of the patient, it is strongly urged that the administrator or physician request that the illness and the period of time both be specified in the written authorization, or be agreed to by the person presenting such consent.

2. One of the results of the increasingly comprehensive services of the modern hospital, especially teaching institutions, is the development and maintenance of *two* types of records relating to a patient. One relates directly to his care and treatment, and is the direct professional reponsibility of the attending physician and of those acting under him. The other has sometimes been described as "educational records," which are typically made by nonmedical personnel as part of their training, or at least for purposes not directly related to the "medical care and treatment" of the particular patient.

It is believed that no record other than that made or approved by the physician in charge, or by a consultant, or resident, or by a registered nurse who is recording her acts or observations made pursuant to special or standing orders, is one which relates to the "medical care or treatment" of the patient, as that phrase is used in the new statute.

Consistent with the above conclusion, it is believed (1) the notes of the attending physician, consultants, and of a resident, plus (2) the patient's chart, are *all* that make up the official hospital record. X-rays have been treated earlier in recommendation 1 herein. Any *other* writings should be kept *separately* but *not* as a part of the patient's official record, for the reason that the persons making such writings are not professionally responsible for the patient, or are not licensed to practice medicine, and are not recording acts or observations made pursuant to orders of the attending physician. Such writings are not authentic records relating to the care or treatment of the patient.

There has been understandable apprehension on the part of some hospital administrators and physicians that the production for inspection or copying of nurses' notes, or of comments by interns, social workers, and others, could embarrass or damage the interests of the patient, the hospital, or the attending physician. It is emphatically recommended that medical staffs and hospital administrators embark on an immediate, intensive, and continuing program of education which has as its

NOTE

Chapter 301, Laws of 1959, as passed by the 1959 Wisconsin Legislature and signed by the Governor, created the following subsections to Section 269.57, Wisconsin Statutes, 1961:

269.57 (3) No evidence obtained by an adverse party by a court-ordered physical examination or inspection under sub. (2) shall be admitted upon the trial or by reference or otherwise unless true copies of all reports, photographs, records, papers and writings made as a result of such examination or inspection and received by such adverse party have been delivered to the party claiming damages or his attorney not later than 15 days after the said reports, photographs, records, papers or writings from any such court-ordered physical examination are received by the said adverse party, provided that in an action for recovery of personal injuries, the party claiming damages shall in return deliver to the adverse party against whom the action is brought a true and correct copy of all reports of each physician who has examined or treated such person with respect to the injuries for which damages are claimed.

(4) Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, the physician, surgeon or other person having custody of any medical or hospital reports, photographs, records, papers and writings concerning such care or treatment shall forthwith permit the person designated in such authorization to inspect and copy such records. Any person having the custody of such records who refuses to comply with such authorization shall be liable to the person receiving such medical care and treatment for all reasonable and necessary costs of obtaining such copies and inspection and for attorney's fees not to exceed $50 plus costs.

The 1961 session of the legislature enacted the following new subsection to Section 269.57, Wisconsin Statutes:

"269.57 (5) The provisions of sub. (4) shall not be applicable to state or county mental hospitals, or to state colony and training schools, or to community mental health clinics established pursuant to s. 51.36."

CONSENT TO EXAMINATION OF PHYSICIAN'S RECORDS

To Dr. _____

I hereby authorize and request you to furnish a copy of the medical records of _____

_____, covering the period from _____19____ to
(State name of patient or "myself")

_____19_____ or to allow those records to be inspected or copied by_____

_____. I hereby release you from all legal responsibility or liability that may arise from the act I have authorized above.

Signed _____

Witness _____ Date _____

CONSENT TO ACCESS TO HOSPITAL RECORDS

o _____, Hospital Administrator, _____Hospital.

I hereby authorize you to furnish a copy of the hospital records of _____

_____, covering the period from_____19____to
(State name of patient or "myself")

_____19_____ or to allow those records to be inspected or copied by _____

_____. I hereby release _____Hospital and you personally from all legal responsibility or liability that may arise from the act I have authorized above.

Signed _____

Witness _____ Date _____

sole purpose the maintenance of patient records which are limited to physical findings, diagnosis, treatment, prognosis, and to acts or observations made in the course thereof, or made pursuant to standing or special orders. If medical staffs, nursing staffs, and personnel under training, will so limit what they write, whether as part of the official patient record, or as part of an educational record, such apprehensions will disappear.

Again, emphasis should be placed on the importance of *physically separating* writings relating to a patient into (1) those made by or under the authority of the attending physician, consultant, or resident, and (2) those made for educational, training, internal, or other collateral purposes. The two categories of writings should be *separated* when the patient is *discharged* from the hospital, since only the first of them relates to the "medical care or treatment" of the patient, and is the only type of record called for by the new statute, and the only type which the physician or hospital should present for inspection or copying.

3. If an authorized person demands more than the above, it should be *refused* and a court allowed to rule on the request. If hospital administrators, physicians, and interested members of the public cannot determine what is embraced in the phrase "medical or hospital reports" relating to the "care or treatment" of the patient, a judicial determination of this question may well become necessary and even desirable.

4. It is further believed that the authorization to inspect and to copy is *personal* to the patient, and for that reason *does not survive* his death. Thus an authorization signed by an executor, administrator or member of a deceased patient's family has no legal effect under subsection (4) of the statute.

5. The potential liability of a hospital for defamation, and the statutory liability of the physician for "wilful disclosure" of professional secrets, deserve brief comment. Both are under the primary duty of not permitting the operation of the statute to be broader than its wording.

Section 269.57 (4) does *not* in words or by implication, give a right to remove any records from the hospital, institution, or a physician's office, the records being the property of the hospital, institution or physician.

As an act of prudence, the hospital or physician should require that inspection and copying be carried on in the presence of a custodian (hospital or physician), or the representative of either. The statute does not require a hospital, institution, or physician to copy any records at the request of a patient or his representative. If a request is made by a patient or his representative, and the request is granted, the hospital, institution, or physician making such copy is entitled to make a reasonable and realistic charge for doing so.

As a precautionary measure to hospital administrative personnel and to physicians, it is suggested that under no circumstances should copies of any medical or hospital reports, which are prepared by a representative of the patient, be signed, initialed or subscribed to in any manner that may indicate authenticity and accuracy of such copies.

6. Few people, other than medically trained personnel, will know what is important in a hospital or medical record. For that reason a hospital librarian or other authorized person, or a physician, may in some situations be able to satisfy a request by making inquiry as to what the patient or his representative really wants from the records, and reading the material relative to the inquiry. This may save a great deal of examining, copying, and inconvenience to everyone concerned.

7. The word "forthwith" used in connection with the right to inspect and copy records does *not* mean "immediately," but "as soon as the convenience of an administrator, a record librarian, or a physician, *reasonably* permits," after taking into account the urgency of prior demands on their time and personnel, and whether advance notice had been given of the demand of the particular patient.

8. When there is any indication that legal proceedings may ensue, the hospital, institution or physician served with a proper demand to examine or copy a patient's records should promptly notify its insurance carrier of this fact, and also the general attorney of the hospital, institution or physician. It is recommended that, in the interest of the patient, the hospital, and the physician, the knowledge of any such demand be given by the person receiving same to the other interested parties.

"CONTROL OF INFECTIONS IN HOSPITALS"—A PUBLISHED REVIEW

The American Hospital Association recently published a monograph reviewing current knowledge about the control of infections in hopitals. Its author is J. C. Colbeck, M.B.B.S., M.R.C.P., chief of service pathology, Shaughnessy Hospital, Vancouver, B.C. The monograph, the 12th in the AHA's series, was distributed to all hospital members of the AHA. It may be purchased for $2 from the American Hospital Association, 840 North Lake Shore Drive, Chicago 11.

County Medical Society Sponsorship of Health Programs

SEVERAL County Societies have sponsored public health clinics in the past year. The clinic may take the form of providing vaccination for some disease, a health examination prior to school, or some similar procedure.

The following questions have been raised:

1. **Where the County Society makes arrangements to have physicians available, is the Society liable for the physicians' acts?**
2. **Where the County Society purchases vaccine and distributes it free at a clinic, is it liable for faulty vaccine?**
3. **Where the County Society purchases vaccine and distributes it free at a clinic, is it liable for negligent administration by an individual physician?**

Legal counsel for the State Medical Society answers the questions as follows:

1. Where the County Society arranges participation by its member physicians, it does *not* assume any liability for their acts, nor warrant that they will not be negligent in the performance of their services.
   All that the Society is doing is *arranging* that one or more physicians will be available for those persons who wish to utilize their services. A County Society cannot practice medicine. Only a licensed physician and surgeon can do so. Similarly, the physician is liable for his own acts. Further, he is liable for the acts of others performed under his specific or general direction. He cannot pass this liability on to the County Society where the Society merely arranges for his participation in a public health program.
2. The County Society will ordinarily *not* be held liable for faulty vaccine unless certain facts are known to its officers and agents which would have caused prudent persons not to distribute it. Thus if the vials show that the vaccine is out of date at the time it is ready for distribution, or the seals have been broken, or the wrong type was described on the packages or vials, the Society might be held responsible if its agents persisted in making distribution despite such facts, and harm resulted.
3. Where the County Society itself purchases vaccine and then arranges for its distribution to physicians for their use in County Society public health programs, the Society *will not* be liable for negligent administration of the vaccine.

Three further observations were made by our legal counsel. First, neither the County Society nor its membership can expect the other to provide a "tent" over its own acts of negligence. Second, while joint liability might be possible where faulty vaccine was distributed and administered, this is, in effect, also separate liability on the part of the Society and the administering physician. Third, it is prudent for a County Society which sponsors a public health program in such an area as immunology to obtain liability insurance after discussion with an experienced insurance advisor. Such insurance should cover the real and basic risks involved with adequate limits.

DO YOU EMPLOY FOUR OR MORE PERSONS?

If you do, then you must pay unemployment insurance taxes.

Employers, including physicians, who employ four or more persons for some portion of the day on at least one day in each of 20 weeks in a calendar year are subject to both the state and federal unemployment insurance tax.

The combined state and federal tax is 3.1% of the first $3,000 of annual wages paid to all employees, of which 2.7% is payable to the state and 0.4% to the federal government.

The report and payment to the federal government is due by January 31 of the subsequent calendar year. Reports and payments to the state are due quarterly during the year in the months of April, July, October, and January. The exact date within the month is set by the state. These reports and payments are due regardless of whether the employer has been notified by either of the governments or has received tax forms.

If a physician or clinic has employed four or more persons in any portion of each of 20 weeks during the current year and has failed to pay the quarterly payments to the state, this should be done promptly so as to keep at a minimum any penalties and interest which will be due. Payment of the federal unemployment insurance tax should be made by January 31.

Medical Staff Rules and Regulations as to Sterilizations

THE STERILIZATION of individuals, for other than therapeutic reasons, is undoubtedly limited in Wisconsin to those cases specifically authorized by statute. An institutionalized criminal or mentally diseased person, under Sec. 46.12 Stats., may be sterilized provided that the elaborate precautions set forth in that statute are followed.

A physician who sterilizes a person for any but clearly therapeutic reasons may be guilty of performing an illegal operation. For that reason it is recommended that additional physicians be called in consultation to determine the therapeutic advisability of the procedure.

Section 46.12, Wisconsin Statutes, 1961:

"46.12 Sterilization of defectives

(1) The department [of public welfare] may appoint a surgeon and a psychiatrist of recognized ability, as experts, who (in conjunction with the superintendents of the state and county institutions who have charge of criminal, mentally ill and mentally deficient persons) shall examine inmates and patients of such institutions as to their mental and physical condition.

(2) The department may submit to the experts and to the superintendent the name of inmates or patients they desire examined, and the experts and the superintendent shall meet, take evidence and examine into the mental and physical condition of the named inmates or patients and report thereon to the department.

(3) If the experts and superintendent unanimously find that procreation is inadvisable the department may authorize an operation for the prevention of procreation.

(4) Before such operation, the department shall give at least 30 days' notice in writing to the husband or wife, parent or guardian of the inmate or patient, if known, and if unknown, to the person with whom such inmate or patient last resided.

(5) The experts shall receive as compensation $10 per day and expenses for the days consumed in the performance of their duties.

(6) The record made upon the examination shall be filed in the department; and semi-annually after the operation, the superintendent of the institution where such inmate or patient is confined shall report to the department his condition.

(7) The department shall state in its biennial report the number of operations performed under this section and the result of the operations."

The illegal character of any but a therapeutic sterilization would not be altered because the patient or his representative consented in writing to the operation.

The following opinion, furnished by legal counsel for the State Medical Society, was provided in answer to an inquiry from a hospital chief of staff and relates to the adoption of medical staff rules and regulations concerning surgery for the sterilization of patients. In substance, however, the opinion covers the law on this subject generally.

* * *

The only Wisconsin statute which specifically relates to the procedure to be followed in sterilization cases relates to criminals, the mentally ill and mentally deficient who are in state or county institutions. A copy of that statute, which is Section 46.12, is printed herein in full because it indicates the safeguards with which the Legislature surrounded the sterilization of individuals who are not able to live in a normal way in society. It seems reasonable to anticipate that if the Legislature were to enact legislation covering sterilization in noninstitutional cases, it would provide at least as careful safeguards for the "normal" majority of the public.

No court decisions have been found in Wisconsin passing on the legal aspects of the sterilization either of institutional or noninstitutional patients. The Attorney General of Wisconsin has ruled on the subject several times, however. In 1932, an Opinion was published, holding, in substance, that even if an institutionalized person were sterilized under all of the safeguards of Section 46.12 of the Wisconsin Statutes, above referred to, there was a serious question, except where the procedure was strictly therapeutic, whether the public officials who requested such surgery and the surgeon who performed the operation were not criminally liable for the common law offense of mayhem, or bodily mutilation.[1]

The Attorney General had ruled four years earlier that an incompetent person could not be legally sterilized except under Section 46.12.[2] The later opinion cited above would thus appear to be an even stricter view.

In 1938, another Opinion of the Attorney General was rendered to the effect that a vasectomy on a person who was not within one of the categories enumerated in Section 46.12 of the Statutes (in other words not in an institution for criminals, the mentally ill or mentally deficient) probably would not

subject the surgeon to criminal liability under the mayhem statute if the surgery was performed to benefit the health of the patient. Attention is invited to the careful wording of the final paragraph of the Attorney General's Opinion which stated:

> "We conclude that vasectomy in the instant case *may* be excusable by reason of necessity to preserve health."[3] (Emphasis added.)

It seems clear that a fair reading of the Attorney General's Opinions justifies the conclusion that the Attorney General of this state has taken a consistently conservative attitude toward sterilization surgery whether performed on certain types of institutionalized patients, such as the mentally deficient, or upon normal persons in the ordinary course of private medical practice.

The performance of sterilization surgery for any but clearly therapeutic reasons could subject the surgeon to criminal penalties and to civil liability for damages on suit either of the patient, spouse, parent, or guardian. Mayhem, or bodily mutilation, is a criminal offense under Section 940.21 of the Wisconsin Criminal Code, and is punishable by a fine up to $5,000, imprisonment up to 15 years, or both.

Rules and regulations on this subject should specify the number of consultants in sterilization cases and specify clinical indication for such operation.

It is recommended that at least two physicians be called into consultation before sterilization surgery is performed. That is the number required by Section 46.12 for institutional cases. Under provisions of Rule 14, of the Joint Commission on Accreditation of Hospitals, such a consultant must be well qualified to give an opinion, and a satisfactory consultation would include examination of the patient and his record and a written opinion signed by the consultant and recorded prior to the surgery, except in emergencies. Finally, the same model rule provides that to the extent possible, consultation by physicians associated in the same office should be avoided so as to reduce the likelihood of an assertion that one associate was backing up the other.

As to the enumeration of the clinical indication for such operations for sterilization, this is a matter for determination by the medical staff. An obvious example would be cancer of the reproductive system of a male or female, or the existence of venereal disease in an advanced stage. Additional examples could undoubtedly be procured from medical authorities.

REFERENCES

1. 21 O.A.G. (1932) 940.
2. 17 O.A.G. (1928) 524.
3. 27 O.A.G. (1938) 416.

PREPRINTED PRESCRIPTION BLANKS

The Narcotics Bureau of the Internal Revenue Service reports that neither Federal law nor administrative regulation prohibits the printing of the physician's narcotic registration number on prescription blanks. However, the Narcotic Bureau prefers that physicians have their prescription blanks printed without including the narcotic registry number. According to the Bureau, if the physician follows the practice of writing in his registry number at the time narcotic prescriptions are issued, it will facilitate the easier detection of forged precriptions.

DRIVERS' LICENSES FOR EPILEPTICS

A person subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin on a temporary basis if:

1. He is recommended for a temporary license by any physician licensed in Wisconsin.
2. He is under medical care.
3. While under medication he is free from seizures.
4. His driving is not otherwise a hazard to public safety.
5. His physician recertifies each six months that he is free from seizures.

The physician makes his certification on a combined questionnaire and recommendation form provided by the Motor Vehicle Department. The physician making such a recommendation must be the physician who is rendering treatment to the epileptic patient. The issuance of a temporary license is discretionary with the Motor Vehicle Department. A denial may be reviewed, however, by a special board of five members. Four of these members are designated by the president of the State Board of Health.**

Reference: Section 343.09, Wisconsin Statutes, 1961.

** The fifth member is the Commissioner of the Motor Vehicle Department, and he and any two of the other members constitute a quorum.

Physicians' Guidelines for Delegation of Duties and Functions to Nurses

THE SOCIETY has been asked on a number of occasions whether a certain procedure could be performed by a nurse. Following are some guidelines for a physician to follow when he considers delegating some function, procedure or duty to a nurse.

Three general principles control delegation to nurses. They are:

1. A physician can lawfully delegate to nurses only those functions, procedures or duties which do not require the exercise of his professional judgment.
2. The nurse must have training and experience in the function, procedure or duty to be delegated by the physician.
3. All such functions, procedures or duties must be performed under the direction or supervision or upon the prescription of a physician.

The "practice of medicine" has been described as the primary professional responsibility of the physician for the total care of his patient. Under Wisconsin law a physician is granted an unlimited license. This is legislative recognition of his comprehensive training and his corresponding professional responsibility. Nurses are not granted such a license nor are they trained for such an overall responsibility. It should not be necessary to reiterate that a nurse cannot "practice medicine", or that a physician cannot, except in a genuine emergency, lawfully delegate the power to practice medicine to her wittingly or unwittingly. This is true even though the nurse is willing to perform a function that requires the exercise of the professional judgment of a physician.

The late Louis J. Regan, who was both a doctor of medicine and an attorney, speaking of industrial nursing, sums up the delegation question in the following words:

> "Authority to diagnose, treat, operate or prescribe cannot be delegated."
>
> LOUIS J. REGAN, *Doctor and Patient and the Law*, 3rd Ed., p. 484

Doctor Regan's text also contains the statement on page 483 that a nurse "should assume no responsibility for service outside the field of her professional training." A professional nurse's training is comprehensive in the field of nursing, but it does not encompass training for the practice of medicine. A nurse who is not trained in a procedure and does not have experience in it should not be allowed to perform it. Professional liability for her acts could attach to the physician who ordered a nurse to perform a procedure beyond her competence.

The training of nurses is divided into two levels. The longer and more comprehensive training leads to professional nursing and the lesser to practical nursing. These are separately defined in the Wisconsin Statutes. Section 149.10(1) of the Wisconsin Statutes defines "professional nursing", and Section 149.10(2) defines "practical nursing". These definitions are as follows:

> "149.10 Definitions. (1) Practice of Professional Nursing. The practice of professional nursing within the terms of this chapter means the performance for compensation of any act in the observation or care of the ill, injured or infirm, or for the maintenance of health or prevention of illness of others, which act requires substantial nursing skill, knowledge or training, or application of nursing principles based on biological, physical and social sciences, such as the supervision of a patient, the observation and recording of symptoms and reactions, the execution of procedures and techniques in the treatment of the sick *under the general or special supervision or direction of a physician*, the execution of general nursing procedures and techniques and the supervision and direction of trained practical nurses and less skilled assistants."
>
> "(2) Practice of Practical Nursing. The practice of practical nursing within the terms of this chapter means the performance of any simple acts in the care of convalescent, subacutely or chronically ill, injured or infirm persons, *or of any act or procedure in the care of the more acutely ill, injured or infirm under the specific direction of a nurse or physician.* A simple act is one which does not require any substantial nursing skill, knowledge, or training, or the application of nursing principles based on biological, physical or social sciences, or the understanding of cause and effect in such acts." (Italics supplied)

Note that in the definition of professional nursing a nurse can treat the sick only "under the general or special supervision or direction of a physician."

Similarly, attention should be given to the italicized wording in subsection (2), quoted above. It says, when read with the first part of the sentence, that "practical nursing" means *not only* simple acts in the care of convalescent and other specified persons, but also *"any act* or *procedure* in the care of the more acutely ill, injured or infirm under the *specific* direction of a [professional] nurse or physician."

The reasonable meaning of the above is that a practical nurse is not limited by statute to what is described in the first part of subsection (2). A

trained practical nurse may *also* perform any act or procedure in the care of the more acutely ill, injured or infirm, *provided* she does so under the specific direction of (a) a professional nurse, or (b) a physician.

Some common sense considerations need to be observed, however. First, neither a physician nor a professional nurse can *lawfully* delegate to a trained practical nurse an act or procedure which would be legally improper for the professional nurse. Second, the phrase "specific direction" reasonably means *in the presence* and under the *immediate supervision* of the physician or professional nurse. This provides the safeguards indicated by the more limited training, skill and experience of the practical nurse.

However, neither type of nurse is authorized by the statutes to diagnose, operate or prescribe. Even the professional nurse can treat the sick *only* under physician supervision or direction.

Supervision or direction of a professional nurse by a physician can take many forms. Physical presence of the physician is not necessarily required in all instances. Many things are done upon the prescription of the physician. In this sense the prescription of a physician means a written order of a physician. This can be either a prescription as used in its normal meaning or an order written in the hospital or other charts.

In the last analysis, the matter becomes one of common sense of the physician, supplemented and guided by his professional training and experience and, equally important, by medical ethics and tradition.

SMS ANNUAL MEETING • MAY 6-7-8-9, 1963

WHAT ARE YOUR RIGHTS IN EMERGENCIES?

Question: Suppose a physician in private practice serves as advisor to his local police department. The department calls him, either to the police station or to a private home, where a belligerent alcoholic is creating a disturbance. The physician gives a hypodermic injection to calm him, without the alcoholic's consent, and with or without the nearby relatives' consent. The alcoholic is believed to be endangering himself or those in his environment. Is the physician within his legal rights as a doctor called by the police?

Suppose a similar sequence occurs with a mentally ill patient. The police are following the physician's orders in these circumstances. To protect the patient and others from the violence of the patient, the physician orders restraints applied. Is he within his legal rights as a doctor called in by the police? Assume that no relative is immediately available to take responsibility of the patient.

Answer: Generally, a physician has no authority to administer a hypodermic injection or any other treatment to a patient without the consent of the patient or someone authorized to act on his behalf. If the patient is mentally incapable of speaking for himself because of intoxication, injury, illness, or insanity, consent must be obtained from someone legally authorized to act on behalf of the patient.

An exception is permitted in the case of an emergency, where the patient's life is endangered. Under these circumstances, the law will presume the patient's consent on the theory that, if the patient were rational and able to make his own decision, he would consent to treatment.

A physician going into a private home has no authority to treat the patient without the consent of the patient, or someone authorized to act on his behalf, unless a bona-fide emergency exists in which the patient's life is endangered. Except with regard to persons committed to state institutions, and other situations where specific statutory authority is granted, the police have no authority to authorize a physician to drug a patient against his will solely because he is creating a disturbance or endangering others. The police have power to restrain such an individual by force, if necessary, although force does not include the use of drugs. However, where a patient becomes so violent that it is necessary to restrain him with drugs, the situation is usually one where treatment can be justified because of a bona-fide emergency. Reference: "The Physician's Legal Rights in Emergencies," J.A.M.A. (Queries and Minor Notes Section) 161:1518 (Aug. 11) 1956.

Legal Limitations on Treating the Sick in Wisconsin

An Interpretation of The Medical Practice Act

HISTORICAL DEVELOPMENT

OVER ONE HUNDRED years ago the medical profession organized nationally for the principal purpose of elevating the standards of medical education and encouraging adequate licensing laws throughout the states.

In a period of less than 20 years before the organizational meeting of the American Medical Association in 1847 at Philadelphia, the number of medical schools in the United States had doubled. Most of these schools were commercial in nature, and their promoters sought to increase enrollment by reducing curriculum requirements and easing graduation and licensing requirements. Sixteen weeks was the accepted length of the college term. Some schools reduced this to thirteen weeks.[1]

The ratio of physicians to population was five times as great as in France, and it was felt that the over supply of doctors and inadequate medical education were "largely responsible for the rise of quackery and charlatanism."[2]

At least as early as 1835 efforts were made by responsible medical colleges and individual eastern state medical societies to upgrade medical education and—of equal importance—to divorce teaching from licensing.

It was soon recognized that these efforts, if they were to be effective, must be made through a concerted, organized national movement.

In 1845 the New York Medical Society adopted the following resolution:

> "WHEREAS, It is believed that a national convention would be conducive to the elevation of the standard of medical education in the United States; and
>
> "WHEREAS, There is no mode of accomplishing so desirable an object without concert of action on the part of the medical colleges, societies and institutions of all the states; therefore be it
>
> "*Resolved*, That the New York State Medical Society earnestly recommends a national convention of delegates from medical societies and colleges in the whole Union to convene in the city of New York on the first Tuesday in May in the year 1846 for the purpose of adopting some concerted action on the subject set forth in the foregoing preamble.
>
> "*Resolved*, That a committee of three be appointed to carry the foregoing resolution into effect."[3]

Morris Fishbein, M.D., states in his book, *A History of the American Medical Association*, p. 22, that this resolution "may be considered the first step toward the formation of the American Medical Association as we know it now."

Organizational problems, lack of cooperation by many medical colleges and public apathy impeded progress.

By 1893, however, fifteen states had enacted medical practice acts which required state examinations of all those who desired to practice medicine.[4] This was the breakthrough, and in a few years most states had adopted similar requirements.

The substantial improvement in the standards of medical education developed at a somewhat slower pace. It was not until 1907 that medical school inspection and rating by the Council on Medical Education gained public recognition and became truly effective. At that time there were 160 medical schools; 82 had been rated above 70, 46 between 50 and 70, and 32 below 50. Medical schools conducted solely for profit and night schools were condemned.[5]

It has, thus, been only during the past 50 years that the states have adopted effective Medical Practice Acts which restrict the unqualified and impose minimal requirements upon those seeking medical licensure. The same may be said of the voluntary efforts to elevate medical school requirements and standards.

Wisconsin presents a typical picture of Medical Practice Act development through the years. It is a story of legislative response to public demand for protection against the incompetent, the quack, the cultist and the charlatan.

The first halting legislative step seeking qualified practitioners appeared in Chapter 27, Revised Statutes of Wisconsin, 1849. It imposed the duty of examining medical students upon the censors of the county and state medical societies.

Successfully completing his examination, the student paid the president of the society $10 for a diploma and membership in the society. This dip-

loma and membership was little more than a badge of honor.

This regrettable state of statutory laxity continued until 1897 when the Wisconsin Legislature enacted our first real Medical Practice Act.[6] This act established the first state board of medical examiners of seven members appointed by the Governor. Three of the appointees were "regular physicians," two were "homeopathic physicians," and two were "eclectic physicians."

The homeopaths and eclectics in Wisconsin each had their own state societies which reflected a national pattern of developing cult practices. Dr. N. S. Davis, the first editor of the *Journal of The American Medical Society*, in a speech before medical editors in Cleveland on June 5, 1883, said:

> "It has appeared from the review of the past that, during the first twenty-five years of our national existence, laws were enacted in nearly all the then existing states designed to protect the people from the impositions of ignorant and designing men claiming power to heal the sick, by prohibiting unlicensed practice, etc.; but which were nearly all repealed or so amended as to render them inoperative during the next thirty years by means of popular prejudices and false representations attendant upon the rise and spread of Thompsonianism and homoeopathy; the one playing upon the mind of the masses with all the power of bold and ignorant empiricism, and the other captivating the credulous tendencies of the more fashionable circles by a mystic transcendentalism inclosed in sugar pellets. The first has died a natural death, leaving a sickly offspring bearing the name of eclectics, while the second, like some medicines, retains its name as a 'trade mark,' and its organization for political influence, while its once transcendental vagaries have long since practically ceased to exert an influence over the treatment of disease."

The homeopaths and eclectics, as standards of medical education improved, gradually abandoned their exclusive theories of treatment and were assimilated into medical practice.

It was not until the 1953 session of the Wisconsin Legislature, however, that the last vestiges of homeopathy and eclecticism were removed from the statutes. In that year the legislature altered the make-up of the board to eliminate the homeopathic representative.

As noted, Wisconsin first enacted the beginnings of an effective Medical Practice Act in 1897 with the establishment of a state examining board. Anyone entering medical practice following its enactment was required to be licensed by the board.

It is interesting to compare the license application requirements, then and now. An applicant had the alternative of submitting to an examination "in the various branches of medicine and surgery" or presenting to the board a diploma from a medical college which required "at least three courses, of no less than six months each, before graduation."[6] Thus practical training with a "respectable" physician remained an avenue to licensed medical practice, but the pattern of effective control of medical qualification was established.

The 1897 Act made no provision for the licensing of those already in medical practice or the date it became effective. The very next legislature required "every reputable physician of good moral character" who wished to continue in practice to register with the board and to present a diploma or other credentials. A registration certificate was then issued which was required to be filed with the county in which the physician practiced. Criminal penalties were provided for noncompliance.[8]

It was only 65 years ago, then, that the unlicensed or uncertified practice of medicine could be prohibited by criminal prosecution.

This requirement of medical license or certificate was a blow to osteopathy whose practitioners had, by this time, established themselves in Wisconsin. The legislature, in its 1901 session, added an osteopath to the board of medical examiners, provided for an examination and licensure in osteopathy, but permitted all those already in practice to continue under a typical "grandfathers" clause.[9]

This same legislature increased the requirements for medical education to four courses of not less than seven months with at least an equivalent of two years of high school and, more significantly, required both an examination and a diploma as a condition to medical license. Those presenting a diploma from a medical school in Wisconsin, however, were exempt from the examination requirement.[9] These amendments marked an end to practical experience with a preceptor as an alternative to medical school education for licensure.

As with eclecticism and homeopathy, the osteopaths gradually began to abandon their cult theory and practice. There was evidence that some of their schools were interested in and were improving their standards and facilities.

In 1949 the Medical Practice Act was amended to eliminate separate licensing of osteopaths. Thereafter licenses to practice medicine and surgery were issued, under the usual conditions, to applicants presenting diplomas from a "medical or osteopathic college with standards of education and training substantially equivalent to the University of Wisconsin Medical School, approved and reorganized by the board." [10]

Osteopaths then in licensed practice were permitted to enroll in a prescribed course in materia medica and pharmacology and, upon successfully completing an examination by the board in those subjects, received an unlimited license to practice medicine and surgery upon surrender of their old license.[10]

As has been seen, effective criminal machinery was available by 1899 to restrain and eliminate unqualified and unlicensed practice in Wisconsin. Apparently, a lack of early and forceful enforcement permitted chiropractic to gain a foothold in Wisconsin by 1915. Clearly they were engaged in medical practice for which, as today, they were incompetent

and unqualified. They were neither licensed nor certified by any state agency.

The 1915 Wisconsin Legislature passed a statute authorizing chiropractors to practice so long as they did not hold themselves out as licensed or registered —and, for good measure, gave special licensure recognition to the itinerant practitioner of medicine or osteopathy.[11]

Then, in a sharp reversal of form, the same legislature substantially increased the educational requirements upon those who applied for a license to practice medicine and surgery.[11]

This important chiropractic breakthrough seriously threatened the entire structure of those laws designed to assure that those who treated the sick in Wisconsin were qualified to do so. In effect the legislature was imposing increasingly more rigorous requirements upon those who were qualified and none whatsoever upon those who were not.

Lurking in the background at this time were the naturopaths, the naprapaths, the faith healers, quacks, charlatans and other cultists ready and eager to follow the lead of the chiropractors to unqualified legislative recognition—or exemption from educational and training requirements.

Thus, one of the significant legislative actions in the development of our Medical Practice Act was the enactment of the Basic Science Law by the 1925 Legislature. It will be considered in some detail later. Generally, however, and with some limited exemptions, it imposed minimal qualifications upon all who would treat the sick in Wisconsin. It is so inclusive in its scope that it is the law most frequently used in prosecutions against the unlicensed.[12] It has effectively subdued the quacks and all cult groups other than the chiropractors who received license recognition in the same session of the legislature.

In summary, Wisconsin joined with other states a hundred years ago in appreciating the absolute need for the imposition of adequate standards to assure qualified health care to its people. These legislative standards and the mechanisms through which they could be enforced developed and improved through the years.

Wisconsin, as did the other states, experienced the growth of cultism and potent efforts to undermine qualifying legislation which had been so painstakingly achieved. The development of these cults and the legislative treatment of them has been briefly traced. The present state of the law will now be examined in some detail.

THE BASIC SCIENCE LAW

General Provisions

In 1925, at the request of the State Medical Society of Wisconsin, the Wisconsin Legislature enacted the Basic Science Law, being the first state to do so. The majority of the states now have laws similar in purpose and effect. The Basic Science Law, which is a part of Chapter 147 of the Wisconsin Statutes, is appropriately named because it enumerates not alone the basic qualifications imposed upon those who would treat the sick, regardless of their method or system of doing so, but because it is also the basic structure upon which the health laws of Wisconsin are predicated.

The Basic Science Law does not authorize one who has successfully passed the examination to engage in any form or manner in caring for the sick. The law is intended only to afford reasonable certainty that, in the basic sciences of anatomy, physiology, pathology and physical diagnosis,[13] those who treat the sick in Wisconsin possess the minimum qualifications.

The Basic Science Law provides that no person shall treat, or attempt to treat, the sick unless be has a certificate of registration in the basic sciences.[14] But this alone does not permit a registrant to treat the sick. He must be otherwise licensed.[15] No examining board for any branch of treating the sick may license, register or admit to its examination any applicant unless he first presents a certificate of registration in the basic sciences, with the exceptions noted in the paragraphs immediately below.[16]

Specifically exempt from the operation of the Basic Science Law are commissioned surgeons of the Army, Navy, and Federal health service,[17] registered nurses,[18] dental hygienists,[19] optometrists,[20] and persons practicing Christian Science.[21] Medical or osteopathic physicians of other states or countries in actual consultation with resident licensed practitioners,[22] persons gratuitously prescribing and administering family remedies or rendering treatment in an emergency are likewise exempted.[23]

All persons who, prior to February 1, 1925 (the effective date of the Basic Science Law), were not registered or licensed to treat the sick but, on that date, were lawfully treating the sick in Wisconsin were granted the opportunity of being registered upon application to the board.[24] Thus, all persons lawfully treating the sick in Wisconsin, other than those above enumerated, must possess a basic science certificate or its equivalent.

Definition of "Treating the Sick" All Inclusive

Section 147.01 (1), Wisconsin Statutes, 1961, defines what constitutes treating the sick in Wisconsin:

> "(a) To 'treat the sick' is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof."
>
> "(b) 'Disease' includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts."

Even such minor departures from complete health, as astigmatism, headaches and partial paralysis,

constitute "disease" within the meaning of the Basic Science Law, and advising as to their care constitutes "treating the sick."[25] The use of roentgenography for diagnosis and treatment is treatment of the sick.[26] The use of natural forces, such as light, heat, air, water and exercise, in the treatment of disease, constitutes treating the sick within the provisions of the Basic Science Law.[27] Diagnosis and treatment of unhealthy conditions of the skin and scalp constitute treating the sick.[28]

Board of Examiners in the Basic Sciences

The State Board of Examiners in the Basic Sciences consists of three lay educators appointed by the Governor to serve for a term of six years each.[29] None of the appointees may be on the faculty of any department teaching methods of treating the sick.[30]

The board keeps a complete record of all applications, examinations, registrations, fees, decisions, orders and proceedings. It is authorized to appoint, subject to the civil service law, such competent and recognized experts as shall be necessary in examinations, as well as clerks. Their compensation, together with the compensation of board members, and all other disbursements by the board, may not exceed in amount the fees received.[31]

Application for Certificate

Application for a certificate of registration must be made to the Board of Examiners in the Basic Sciences. Such application must be accompanied by satisfactory evidence of good moral character and preliminary education equivalent to graduation from an accredited high school of this state, together with a fee of $10.[32] The applicant is not required to disclose the professional school he attended or the system of treating the sick which he intends to pursue.[33]

The preliminary high school requirement is waived only as to those applicants who were attending a professional school which was teaching the basic sciences on February 1, 1925.[34]

Basic Science Examination and Certificate

The examinations are conducted at least four times a year at times and places fixed by the board, and are both written and practical.[35] The applicant is examined in anatomy, physiology, pathology and physical diagnosis,[36] and if he achieves the grade of 75 per cent in each subject, he receives a certificate in the basic sciences signed by the president and secretary of the board. In the event the applicant fails in one subject only, he may be re-examined in that subject at any examination within one year without further fees, but if he fails in two or more, he must re-apply and be re-examined in all subjects.[37]

If the state boards of medical or dental examiners accept in whole or in part certifications from their national boards of examiners, the basic science board may accept such national certificates in lieu of their own examinations.[38]

Since a certificate in the basic sciences does not authorize one to engage in the practice of treating the sick, compliance with the law is merely a condition precedent to taking the examination of one of the licensing boards. The Basic Science Law in no manner supplants conditions imposed by the various licensing boards.[39]

Reciprocity

The board may issue a certificate to an applicant who presents satisfactory evidence of having passed examination in the basic sciences before a legal examining board or officer of another state, or of a foreign country, if the standards are as high as those of this state, and upon the payment of a fee of $15.[40]

Court Review

The action of the board in granting or denying a certificate is subject to review by appeal in the manner provided in Chapter 227, Wisconsin Statutes. The applicant affected, or any state examining board for any branch of treating the sick, may take such appeal.[41]

The court may then affirm, reverse, or modify the decision of the board.[42]

Revocation

A certificate of registration in the basic sciences is subject to revocation for the causes and in the manner provided in Section 147.20, Wisconsin Statutes.[43] For discussion of that section and procedure under it see "Revocation or Suspension of License," page 21, of this article.

Enforcement of the Basic Science Law

The definitions of "treat the sick" and of "disease" are sufficiently broad to encompass even the "hair restorer" and the "headache reliever" as has been seen. All who "treat the sick" are required to have a certificate in the basic sciences with the noted exceptions.

Of equal importance is the fact that the law is readily enforceable. In addition to a criminal penalty of a fine or imprisonment,[44] the board of medical examiners or the district attorney of the proper county may bring action in the name and on behalf of the state to enjoin a violation.[45] It has been the latter procedure which has proved most effective.

LICENSING REQUIREMENTS AND PROCEDURES

As has been noted, a basic science certificate does not entitle its holder to treat the sick. This is further clarified in Section 147.14 (1), Wisconsin Statutes, 1961:

"147.14. Practice. (1) No person shall practice or attempt or hold himself out as authorized to practice medicine, surgery, or osteopathy, or any other system of treating the sick as the term 'treat the sick' is defined in s. 147.01 (1) (a), without a license or certificate of registration from the state board of medical examiners, except as otherwise specifically provided by statute."

Several exceptions to this provision are created by virtue of a statutory provision that exempts those engaged in healing the sick through Christian Science,[47] while still another provision exempts from licensure requirements those engaged as commissioned officers of the Army, Navy, or Federal public health service, or licensed practitioners in medicine and surgery or osteopathy and surgery of other states or countries who may be in actual consultation with resident licensed practitioners of this state. Nor does this law apply to gratuitous prescribing and administering of family remedies, or to treatment rendered in an emergency.[48]

Still others are exempt from the provisions of this section by reason of their compliance with other specific licensing statutes, such as those dealing with chiropractic and optometry.

However, there is no "No Man's Land" in licensure in Wisconsin. Specific theories or systems of treating the sick not recognized in Wisconsin may not be pursued as a vocation. This includes such cultists as naturopaths, naprapaths, and others. To treat the sick in Wisconsin, one must be licensed specifically to exercise that privilege under the Wisconsin licensure law.[49]

Each specific licensed field in Wisconsin is under the jurisdiction of one of the several licensing boards. The State Board of Medical Examiners licenses applicants for the practice of medicine and surgery, physical therapy, and podiatry.

Other than medicine and surgery, each licensed field of practice is limited by law either in the scope of its practice or in the modalities or treatment methods it may apply. It is not the purpose of this article to set forth those limitations. Licensure requirements, application procedures, powers and organizations of the respective licensing boards, license revocation and disciplinary procedures will be treated, however, as will statutory provisions of particular interest and importance to the particular field of practice involved.

MEDICINE AND SURGERY

Examining Board

The examining body for applicants for license to practice medicine and surgery is the state board of medical examiners, which is composed of eight licentiates, one of whom must be an osteopath, appointed by the governor for four-year terms.[50] No instructor, stockholder, member of, or persons financially interested in any school having a medical or osteopathic department, is eligible.[51]

The board has its permanent office in Madison and is required to meet at least four times a year, one meeting of which must be on the second Tuesday of January at Madison for the purpose of electing its officers.[52]

It keeps a register of the applications it receives and the licenses and certificates of registration issued.[53]

All persons licensed or registered by the board are required to register with it annually and pay the required fee. These include those licensed to practice medicine and surgery;[54] osteopaths,[55] podiatrists,[56] and physical therapists.[57]

This annual re-registration requirement must be complied with in January of each year and the board is required to publish a printed list of all registrants before March 11 and mail a copy to each registrant and to designate law enforcement officials including the sheriff and district attorney of each county.[58]

All applications for licensure from the board must be presented at the time and place designated by it.[59] In this connection, the board in the exercise of its inherent rule-making authority, has adopted a wide range of regulations detailing its specific requirements as to the procedure in making application for licensure.[60] These are subject to frequent change; therefore, it is suggested that specific inquiry be directed to the offices of the State Board of Medical Examiners, 1414 South Park Street, Madison 15, Wisconsin.

Educational Requirements

The minimal educational requirements of an applicant for license to practice medicine and surgery are summarized in Table 1, Column 1, page 18.

The medical or osteopathic college from which the applicant has graduated must be "substantially equivalent" in its standards of education and training to the University of Wisconsin Medical School and approved and recognized by the board on this basis.[61]

Inquiry as to whether a particular college has been approved should be directed to the office of the board. As to colleges not already approved and recognized, the board or a designated agent is required to conduct an investigation and a public hearing with notice to all interested parties.[62]

Examination and Licensure

The State Board of Medical Examiners examines all applicants in subjects usually taught in a reputable medical school.[63] The board, if six of its members find the applicant qualified, then issues a license to practice medicine and surgery, signed by the president and secretary, and attested by the seal of the board.[64]

TABLE 1—*Requirements of an Applicant for a License in Medicine and Surgery, Podiatry, Chiropractic, Optometry, Dentistry and Nursing*

Applicant for License in	Preliminary	Undergraduate	Professional and Personal	Additional Requirements	Application Fee
Medicine and Surgery (Secs. 147.15; 147.17(1))	Equivalent to graduation from an accredited high school of this state.	Equivalent to the premedical course at the University of Wisconsin, including physics, chemistry and biology.	Good moral and professional character; diploma from reputable professional college with standards of education and training substantially equivalent to the University of Wisconsin Medical School.	If not required by the professional school for graduation, internship of at least 12 months in a reputable hospital; a verified statement of familiarity with health requirements on communicable diseases.	$45, with an additional $5 if license issued.
Podiatry (Sec. 154.02)	Equivalent to graduation from an accredited high school.	One year in an accredited college of liberal arts or science.	Completion in an accredited school of podiatry, a course in anatomy and physiology of the feet, and diagnosis of foot ailments and deformities, materiamedica, chiropodial orthopedics, bacteriology, pathology, histology, therapeutic chemistry, and minor surgery and bandaging pertaining to ailments of the feet, and the mechanical treatment of congenital or acquired deformities of the feet. Applicant must be of good moral and professional character and more than 21 years of age. No degree which entitles one to practice podiatry shall be accepted from any recognized university or college of chiropody except that of "Doctor of Surgical Chiropody or its equivalent. Any school conferring the "DSC" or its equivalent degree must have a professional curriculum of 4 years, with at least 32 weeks and at least 30 class hours each week, with adequate clinical or hospital facilities.	None.	$25
Chiropractic (Sec. 147.23(3))	None	2 years of study for a Bachelor of Arts or Science degree in a college accredited by the North Central Association of Colleges and Secondary Schools.	Graduation from a reputable school of Chiropractic, approved and recognized by the Board of Examiners in Chiropractic, having a residence course of not less than 36 months, consisting of not less than 3,600 60-minute class periods. Satisfactory evidence of good moral character.	Certificate of Registration in basic sciences.	$25
Optometry (Secs. 153.04 and 153.05)	None	None	Good moral character, 21 years old. Graduation from an accredited college of optometry approved and recognized by Optometry Board, and 5 years approved training in optometry, of which 3 years must have been in an accredited school or college of optometry.		$35 for resident $50 for non-resident. $10 for subsequent examination in event of failure.
Dentistry (Sec. 152.03)	Equivalent to graduation from a high school or academy in Wisconsin offering a four-year curriculum beyond the 8th grade.	2 years college preparation leading to a baccalaureate degree including English and the sciences of physics, biology and chemistry.	Satisfactory completion of dental school and college recognized by the Wisconsin State Board or Dental Examiners with a curriculum of at least four years of 32 weeks each.		$25
Nursing (a) Registered Nurse Sec. 149.04	Equivalent to high school education.		Good moral character, citizen, or intends to be citizen. Diploma of graduation from an accredited school of nursing.		$25
(b) Practical Nurse Sec. 149.09(2)	2 years of high school or equivalent.		Good moral character, citizen, or intends to be citizen, 18 years of age. Completed work prescribed by an accredited school for trained practical nurses approved by the board.		$15

Licensure without Examination

The board may license without examination a person holding a license to practice medicine and surgery in another state, if in such state the requirements imposed are equivalent to those of this state, upon presentation of the license and a diploma from a reputable professional college approved and recognized by the board, or an honorably discharged surgeon of the Army or Navy, or of the Federal public health service, upon filing of a sworn and authenticated copy of his discharge.[65]

Applicants from Unapproved Foreign Medical Schools

As has been noted, an applicant for a license to practice medicine and surgery must present to the board of medical examiners a diploma from a medical or osteopathic college *approved and recognized by the board.* A number of foreign medical schools are not. Some which are, have that approval only during specified graduating years.

A carefully restricted opportunity for applicants who cannot present a diploma from such an approved school was provided by the 1957 session of the Wisconsin Legislature.[66]

If the board is persuaded that a graduate of an unapproved and unrecognized foreign medical school has preprofessional and professional training substantially equivalent to that offered by the University of Wisconsin premedical and medical schools, it may admit the applicant to examination and issue a license to practice medicine and surgery.

The board may ask the dean of a medical school, which has been approved by the board, to examine or have examined the applicant to determine whether the pre medical and medical training is substantially equivalent to that offered in the dean's school. In lieu of the inquiry of a dean, the board may accept, either in whole or in part, the marks received by the applicant in examinations conducted by the educational council for foreign medical graduates.

Only 25 licenses a year may be issued to applicants. The fee is based upon the time of the examiner and board but is not less than $100 or more than $300.

Temporary Licenses to Practice Medicine and Surgery

Several months may elapse between the time an obviously qualified physician applies for a Wisconsin license and the board conducts its next examination.

Provision has been made by statute under which any two officers of the board of medical examiners may cause to be issued a temporary license to practice medicine and surgery to such an applicant.[68]

Two such officers must first find, however, that an emergency need for medical personnel in a particular area exists and the temporary license must limit its holder to practice in that area.

This statute contemplates that the temporary licensee will submit to the next board examination for permanent license. To that end a temporary license expires within 30 days after the next examination for permanent license is conducted by the board or on the date the board grants or denies the applicant a license—whichever date first occurs. If the temporary licensee does not take the examination, the license expires on the day the board begins its examination of applicants.[69]

A temporary license may be issued only once to the same person; and, during the period it is in force, the basic science law certificate requirement is suspended, assuming the temporary licensee has applied for a basic science certificate and the application has been accepted by the basic science board.

The fee for a temporary license is $25.

Temporary Educational Certificates in Medicine and Surgery

For the stated single purpose of providing opportunities in Wisconsin for the postgraduate education of certain persons in medicine and surgery who do not possess a license and, presumably, are not eligible for one, the board of medical examiners may issue educational certificates under prescribed conditions.[70]

An applicant for such a certificate must have training in medicine and surgery satisfactory to the board. It may be issued for a period not to exceed one year. It may be renewed annually, at the discretion of the board, for not more than four additional years. No more than 50 temporary educational certificates can be issued annually and no more than 150 may be outstanding at any one time.[71]

Limitations on Practice

The certificate permits its holders to take postgraduate educational training only in a teaching hospital which maintains standards prescribed by the board and are commensurate with those of nationally recognized accrediting organizations. He may render services to patients only under the direction of a person licensed to practice medicine and surgery in Wisconsin.

Under such medical direction, the educational certificate holder may prescribe drugs other than narcotics and sign certificates, reports and other papers required, or for the use of public authorities which are required of or permitted to one licensed to practice medicine and surgery.

Additional restrictions are these: The certificate holder must confine his training and practice within the hospital in which he is taking his postgraduate education, and neither he nor the hospital may receive fees or other income for his services from any patients treated by him.[72]

The Status of Externs, Interns and Residents

Externs

The term "extern" or "preceptee" refers to advanced medical students in their clinical years, who have not as yet completed their college course in medicine. A preceptee performs certain assisting and observing functions, either during a vacation period, or during his fourth year of medical study, under the supervision of a licensed physician. Preceptees participate in this portion of their training under an arrangement between supervising physicians and the medical school. The hospital has no jurisdiction over them.

A preceptee is generally an assistant to a physician. The duties delegated to a preceptee by a physician are usually very much limited and relate only to observation. Thus, a situation would seldom arise in which an act of a preceptee might cause injury. A physician presumably has the duty to see to it that the preceptee is delegated no duty which would call for discretion or judgment on his part. However, a negligent act on the part of a preceptee in the treatment of a patient is a responsibility of the physician under whom he is working.

Interns

An "intern" is generally understood to mean one who is engaged in a twelve months' period of advanced study immediately subsequent to the completion of his college course and prior to the granting of his medical license. Internship is a prerequisite for the granting of a license to practice medicine and surgery in Wisconsin. After one year of internship, unless his medical school requires a longer period of internship as a condition of graduation, the intern must be licensed and have the legal status of a practicing physician.

An intern does not have the full legal status of a licensed practitioner. He does have certain functions of a medical nature which he is permitted to perform. The Wisconsin Supreme Court has admitted that interns are not subject to the Medical Practice Act because the Wisconsin Statutes require an internship as a part of one's medical education prior to licensure. The court summarized the legal status of an intern in Wisconsin as follows:

> "This is a legal sanction of the performance of such duties on the part of interns as are usually and ordinarily performed by them. The performance of such duties does not constitute the practice of medicine, or a representation

that the intern is authorized to practice medicine."[73]

Interns are not within the provisions of the so-called "medical privilege statute."

When it comes to responsibility for negligence of interns while performing their customary duties, it is clear that they have a personal responsibility. The responsibility for their acts, however, may extend to the physicians under whom they are working, or to the hospital employing them. The law generally holds the intern to be an employee or servant, inasmuch as he is obliged to spend his days and nights at the hospital to render any administrative or medical service provided by the hospital through its agents, within the range prescribed by propriety and custom. This interpretation of his position is recognized by the courts under the Workmen's Compensation Act, which extends employee protection to interns injured in the performance of their duties in the hospital.

Wisconsin has held that the hospital is responsible for liability arising out of the acts of interns in the performance of duties which are customarily performed by them. However, where the intern is acting under the direct supervision of a physician during the course of an operation, the hospital is absolved from responsibility and his acts become those of the physician who has charge of the work.

Residents

A "resident" is usually understood to mean a physician engaged in postgraduate medical education beyond the period of internship, and under the supervision of a hospital medical staff or a medical faculty. A resident is required by Wisconsin law to hold a regular, permanent license to practice medicine. He is as fully responsible for his acts or omissions as any other licensed practitioner.

Itinerants

The following statute specifically governs licensure of the itinerant practitioner to practice any form or system of treating the afflicted:

> "147.18 Itinerants. Itinerant practitioners of medicine, surgery or osteopathy or of any form or system of treating the afflicted shall obtain an annual license in addition to the regular license or certificate of registration, and shall pay therefor two hundred fifty dollars per annum. Persons practicing medicine, surgery or osteopathy or professing or attempting to treat or heal ailments or injuries of the human body who go from place to place at regular or irregular intervals less frequently than once a week, are itinerant practitioners."

Revocation or Suspension of License

Four procedures have been established by statute for the revocation or suspension of a license or certificate issued by the Wisconsin State Board of Medical Examiners:

By Civil Action

The district attorney is authorized to bring civil action in circuit court against the holder of a license to practice medicine and surgery and in the name of the state to revoke or suspend his license upon a verified complaint received by him charging the holder of the license with having been guilty of immoral or unprofessional conduct, or with having obtained a license by fraud, perjury or error.[74] The same subsection sets out certain other procedural features of such a suit.

The words "immoral or unprofessional conduct" are defined by section 147.20 (1), as follows:

> "(a) Procuring, aiding or abetting a criminal abortion; (b) advertising in any manner either in his own name or under the name of another person or concern, actual or pretended, in any newspaper, pamphlet, circular, or other written or printed paper or document the curing of venereal diseases, the restoration of 'lost manhood,' the treatment and curing of private diseases peculiar to men or women, or the advertising or holding himself out to the public in any manner as a specialist in diseases of the sexual organs, or diseases caused by sexual weakness, self-abuse or excessive indulgences, or in any diseases of a like nature or produced by a like cause, or the advertising of any medicine or any means whatever whereby the monthly periods of women can be regulated or the menses re-established, if suppressed, or being employed by or in the service of any person, or concern, actual or pretended so advertising; (c) the obtaining of any fee; or offering to accept a fee on the assurance or promise that a manifestly incurable disease can be or will be permanently cured; (d) wilfully betraying a professional secret; (e) indulging in the drug habit; (f) conviction of an offense involving moral turpitude; (g) engaging in conduct unbecoming a person licensed to practice or detrimental to the best interests of the public."

The license of a physician who attempts to perform an abortion may be revoked or suspended, and the fact that he was acquitted of the same charge in a criminal action does not bar a proceeding under this section.[75] Nor is the time within which to bring such action, after the offense has been committed, important.[76] The attorney general has further ruled that a physician who directed a patient to an abortionist who did, in fact, perform an abortion, is guilty as an accessory before the fact, and his license is subject to revocation or suspension under this section.[77]

Subject to the limitation that any act in question must occur in the course of professional conduct, defrauding through use of the mails has been ruled to be a crime involving moral turpitude under section 147.20, while violation of the Federal Narcotic Act probably is not; indulgence in a drug habit is immoral or unprofessional conduct under section 147.20.[78]

By Action of the Board

The statute also provides that when any person licensed by the State Board of Medical Examiners is convicted of a crime committed in the course of his professional conduct, the clerk of the court shall file with the board a certified copy of the information and of the verdict and judgment; and upon such filing the board shall revoke or suspend

the license or certificate. The board is likewise under a duty to revoke or suspend any such license or certificate upon proof of a Federal conviction of a crime committed in the course of the holder's professional conduct.[79]

The license of a physician who has been convicted of a crime cannot be revoked or suspended by the board unless the crime was committed in the course of his professional conduct. If the crime of which the person is convicted, however, involves moral turpitude, the license may be revoked or suspended by a circuit court action described in part (a) of this section.[80]

Revocation or suspension of a license under this section requires affirmative action by the board, and the right to practice continues until such action is taken.[81] There is no time limitation within which the board must act. In the event, however, that the board suspends rather than revokes the license or certificate, the suspension must be for a definite period not exceeding two years, and the board has the power, upon a proper showing, to restore it at any time within the period.[82]

The board has no authority to restore a revoked license.[83] It may be restored only after a first revocation, and then only by subsequent order of the trial court upon notice to the district attorney who prosecuted, or in the event of his disability, his successor in office, and upon written recommendation of the president of the State Board of Medical Examiners with a finding by the court that the applicant is of good moral and professional character and that justice demands the restoration.[84]

The 1961 Legislature enacted a new subsection allowing the board, without formal proceedings, to place a license holder or certificate of registration holder on probation and temporarily suspend such license or certificate of registration for two three-month periods. However, the board must know or have good cause to believe that the person has been guilty of immoral or unprofessional conduct. The board may also warn and reprimand the holder of the license or certificate and may request the State Medical Grievance Committee to act. All of the actions of the board under this section are subject to review as provided by law.[81a]

State Medical Grievance Committee

In 1935 there was enacted the section quoted below.[85] It was designed to provide a body of qualified public officers to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery which are inimical to the public health. The statute follows:

"**147.195. State medical grievance committee.** The state health officer, the secretary of the state board of medical examiners, and the attorney general or deputy attorney general, or their representatives, are hereby constituted ex officio a state medical grievance committee, to investigate, hear and act upon practices by persons licensed to practice medicine and surgery under 147.17, that are inimical to the public health. The state health officer shall be chairman of the committee. Meetings of the committee shall be held at the call of the chairman. Any member thereof shall have power to subpoena and swear witnesses, and take evidence. The committee shall have power to warn and to reprimand, when they find such practice, and to institute criminal action or action to revoke license when they find also probable cause therefor under criminal or revocation statute, and the attorney general may aid the district attorney in the prosecution thereof. The records of said committee shall be kept by and be in the custody of the chairman thereof. No member of said committee shall receive any extra compensation therefor, nor other than his actual expenditures in attending upon his duties thereon. All divisions, officials and employees of state and local government are authorized to cooperate with the committee in conducting investigations and by making available to it pertinent data in their possession."

MASSAGE AND HYDROTHERAPY

The 1953 session of the Wisconsin Legislature repealed that section of the statutes which authorized the registration of masseurs by the state board of medical examiners.[86] It permitted those previously registered to continue in practice under the same conditions and limitations as were imposed by law prior to the repealer.[87] Because there are a number of these "grandfathers" still in practice in Wisconsin, the nature and scope of their authorized practice are set forth.

Limitations on Practice

Masseurs are not permitted to treat a specific disease except upon the advice of a licensed medical physician.[88] Assuming such advice, the masseur is limited to the practice of massage, hydrotherapy and educational gymnastics in his treatment.[89] He may use a galvanic generator, diathermy, infra-red ray, and ultra-violet light for massage purposes.[90]

An opinion of the attorney general defines "massage and hydrotherapy" as: "A method of rubbing, kneading, or stroking of the superficial parts of the body by the hand or an instrument, for the purpose of modifying nutrition, restoring power of movement, breaking up adhesions, etc., and hydrotherapy is the treatment of disease by means of water."[91]

PHYSICAL THERAPY

With the elimination of further registrations in massage and hydrotherapy, the 1953 session of the Wisconsin Legislature, which enacted the masseur repealer, recognized the growth, acceptance, training and education of the qualified physical therapist. It provided authority in the state board of medical examiners to accept applications from physical therapists meeting stated qualifications; to conduct examinations through a committee of physical therapists appointed by it; and to issue certificates of registration to successful applicants.[92]

Physical therapy is defined, by statute, as treatment utilizing "physical, chemical and other proper-

ties of heat or cold, light, water, electricity, massage and therapeutic exercises, including posture and rehabilitation procedures.[93]

Limitations on Practice

Physical therapy, as above defined, is a part of the practice of medicine and some other licensed or registered practices in Wisconsin. Persons licensed or registered in this state, under another law, to engage in a practice which includes physical therapy are not affected by the legal limitations imposed upon it.[94]

All other persons practicing physical therapy or adopting titles, such as "physical therapy technician," must be registered by the state board of medical examiners.[95]

There are further restrictions on the practice. The registered physical therapist may not use Roentgen rays or radium for any purposes nor may he use electricity for surgical purposes, including cauterization.[96] And, most significantly, he may not undertake treatment unless it be under a prescription and the direct supervision of a person licensed to practice medicine and surgery.[97]

OSTEOPATHY

Osteopaths are no longer licensed as such in Wisconsin. In recent years the Wisconsin Legislature became convinced that osteopathy, as with homeopathy, had abandoned its cult background and therapy. It enacted legislation providing that if an applicant presented to the state board of medical examiners a diploma from an osteopathic college *with standards of education and training substantially equivalent to the University of Wisconsin Medical School* and which school was approved by the board, a license to practice medicine and surgery would be issued. This is conditioned, of course, upon the applicant meeting all other prequalification requirements for medical licensure including examination.[98] These are set forth in the table appearing at page 8.

Provision was made in the same legislative enactment through which those osteopaths, previously licensed by the board to practice osteopathy and surgery, could qualify for the unlimited license to practice medicine and surgery. Seeking the unlimited license, the osteopath is required to take a prescribed course, approved by the board of medical examiners, in materia medica and pharmacology and to pass the same examination in the subjects as given to a medical school graduate at any regular meeting of the board.[99]

Limitations on Practice

The graduate of an osteopathic school who holds a license to practice medicine and surgery is prohibited from using the title "doctor of medicine" or the letters "M.D."[100] Other than that his license to practice medicine and surgery is identical in its unlimited privileges as that of the doctor of medicine.

There are a sufficient number of osteopaths, licensed as such, and still in practice, who did not seek or gain the unlimited license to warrant a brief statement of the limitations imposed upon their practice.

Osteopathy is frequently defined as a form of "manual treatment of disease." It is a system of therapy without the use of drugs, based on the theory that diseases are chiefly due to mechanical derangement in the structure of the human body, which can be remedied by manipulation.[101]

Under the accepted principle that osteopaths are licensed to practice only "osteopathy and surgery" and not "medicine and surgery," the attorney general has issued numerous opinions confining the practice of osteopathy to its own system or philosophy of treating the sick.[102] Thus it has been ruled by the attorney general that an osteopath cannot prescribe medicines except those necessary as a part of an actual surgical operation.[103]

Persons licensed to practice osteopathy and surgery may not enlarge the legal scope of their activities merely by undertaking to perform functions properly belonging to the practice of medicine alone. Since vaccination, and the use of serums, antitoxins and the like is a form of preventive medicine, an osteopath is forbidden their use in his practice, for, according to the attorney general, "The point is that if an osteopath is qualified to practice medicine he may become licensed to do so. . ."[104]

PODIATRY

The practice of podiatry, previously called chiropody, has been legislatively recognized and controlled in Wisconsin since 1917. Its practitioners are registered by the state board of medical examiners after the applicant meets the prequalification requirements outlined in the table appearing at page 14, and, successfully passes an examination conducted by three licensed podiatrists appointed by the board.[105]

The scope of podiatry practice is defined by statute:

> "(1) The practice of podiatry is the diagnosis or mechanical, medical or surgical treatment, or treatment by the use of drugs, of the feet, but does not include major surgery or the use of a general anesthetic. Diagnosis or treatment shall include no portion of the body above the feet except that the diagnosis and mechanical treatment shall include the tendons and muscles of the lower leg insofar as they shall be involved in the conditions of the feet."[106]

Since podiatrists attempted to obtain authorization for the use of narcotics from the legislature and were refused, it is clear that they may not use narcotics.[106a]

Although no one is permitted to practice podiatry unless registered as such by the board of medical examiners, physicians are specifically exempted.[107]

CHIROPRACTIC

The practice of chiropractic has been licensed in Wisconsin since 1925. It has its own licensing board consisting of three chiropractors, appointed by the Governor with the advice and consent of the Senate.[108]

An applicant for chiropractic license must present to the board a certificate of registration in the basic sciences and otherwise meet the prequalification requirements outlined in the table appearing at page 8.[109]

The theory of chiropractic is set forth in rules which have been adopted by the State Board of Examiners in Chiropractic. It is based on the premise that disease or abnormal function is caused by interference with the normal nerve transmission and expression, due primarily to pressure, strain, irritation or tension upon the spinal nerves as they emit from the spinal column, as a result of bony segments, especially of the spine, deviating from their normal juxtaposition.[110]

Limitations on Practice

The practice of chiropractic is defined by board rule. It provides as follows:

> "The practice of chiropractic consists of the analysis of any interference with normal nerve transmission and expression and the correction thereof by a specific adjustment with the hands of the abnormal deviations of the bony articulations especially of the spine, for the removal of the cause of disease, without the use of drugs or surgery. The term, analysis, is construed to include the use of x-ray and other analytical instruments generally used in the practice of chiropractic." [111]

OPTOMETRY

Optometrists are licensed in Wisconsin by a board of five members, appointed by the Governor, and designated the Wisconsin Board of Examiners in Optometry.[112] An applicant for a license in optometry must meet the prequalification requirements outlined in the table appearing at page 8, and successfully pass an examination conducted by the board. No basic science certificate is required.[113]

Limitations on Practice

Optometry is defined as:

> "The practice of optometry is defined as follows: The employment of any means other than drugs to determine the visual efficiency of human eyes or the measurement of the powers or defects of vision; the furnishing, using or employment of any means or device designed or calculated to aid in the selection or fitting of spectacles or eyeglasses; and the adaptation of lenses, prisms and mechanical therapy to aid the vision of any person."[114]

The practice of optometry is the employment of any means, other than the use of drugs, for the measurement of the powers of vision and the adaptation of lenses, prisms and mechanical therapy for the aid thereof.[115] It is a mechanical trade, not a profession. The legislature "has dealt with optometry as a skilled calling, not as a profession involving a relation of special confidence between practitioner and patient.[116]

No one is permitted to practice optometry, as it is defined above, unless he has been licensed by the Board of Examiners in Optometry.[117] Physicians are excepted, however.[118] So too are dispensing opticians to the limited extent that they may take necessary facial measurements and process, fit and adjust mountings, frames, lenses and kindred products in the filling of prescriptions of duly licensed physicians or optometrists for ophthalmic lenses. They may also duplicate or replace lenses without a prescription in those instances where "optometric service" is not required.[119]

ENFORCEMENT OF THE MEDICAL PRACTICE ACT

The obligation of enforcing the Medical Practice Act has been that of the State Board of Medical Examiners for more than 20 years.[120] Enforcement funds are secured from the annual re-registration fee paid to the board by its licensees and registrants.

Both criminal and civil remedies are available to the board. Violations of the Medical Practice Act call for a fine of not less than $100 nor more than $500, or imprisonment for not less than 60 days nor more than one year, or both.[121]

The civil remedy is that of injunction. The board or the District Attorney of the proper county may investigate alleged violations and bring action in the name and in behalf of the State of Wisconsin against a violator to enjoin him from further violations.[122]

CITATIONS

Note: All references below, beginning with the abbreviation "Sec." are from the designated chapters and sections of the 1959 Wisconsin Statutes as amended by the Laws of 1961. References containing the abbreviation "Wis." are from the designated volume and page of decisions of the supreme court of Wisconsin. References containing the abbreviations "Atty. Gen." are from the designated volume and pages of the official opinions of the Attorney General of Wisconsin.

1. *A History of the AMA*, p. 21
2. Report of Committee on Medical Education, *Transactions of the AMA*, 1848.
3. *A History of the AMA*, p. 22
4. *A History of the AMA*, p. 154
5. *A History of the AMA*, p. 250
6. Chapter 264, Laws of 1897
7. *A History of the AMA*, p. 111
8. Chapter 87, Laws of 1899
9. Chapter 306, Laws of 1901
10. Chapter 431, Laws of 1949
11. Chapter 438, Laws of 1915
12. Chapter 284, Laws of 1925
13. Sec. 147.01 (1), (c)
14. Sec. 147.02
15. Sec. 147.14 (1)
16. Sec. 147.04
17. Sec. 147.02; Sec. 147.19 (1)

18. Sec. 147.02
19. Sec. 147.01 (2)
20. Ibid
21. Sec. 147.02; Sec. 147.19 (2)
22. Sec. 147.02; Sec. 147.19 (1)
23. Sec. 147.02; Sec. 147.19 (1)
24. Sec. 147.09
25. Nickell v. State, 205 Wis. 614
26. 16 Atty. Gen. 560
27. 20 Atty. Gen. 107
28. 21 Atty. Gen. 1135
29. Sec. 147.03
30. Ibid
31. Sec. 147.12
32. Sec. 147.05
33. Sec. 147.06
34. Sec. 147.05; 22 Atty. Gen. 297
35. Sec. 147.06
36. Ibid; Sec. 147.01 (1), (c)
37. Sec. 147.07
38. Sec. 147.06
39. 26 Atty. Gen. 110
40. Sec. 147.08
41. Sec. 147.11
42. Sec. 227.20 (1)
43. Sec. 147.10
44. Sec. 147.21
45. Sec. 147.205
47. Sec. 147.19 (2)
48. Sec. 147.19 (1)
49. Sec. 147.14 (1)
50. Sec. 147.13 (1)
51. Ibid
52. Sec. 147.13 (2)
53. Sec. 147.13 (5)
54. Sec. 147.175
55. Sec. 147.175
56. Sec. 154.04
57. Sec. 147.185 (4)
58. Sec. 147.175 (1), (3)
59. Sec. 147.15
60. Ibid; Wisconsin Administrative Code, Med 1.01–40.08
61. Sec. 147.15
62. Ibid
63. Sec. 147.16
64. Sec. 147.17
65. Ibid
66. Sec. 147.15 (1m)
67. Ibid
68. Sec. 147.15 (2)
69. Ibid
70. Sec. 147.151 (2)
71. Sec. 147.151 (1)
72. Ibid
73. Nickley vs. Eisenberg (1931) 206 Wis. 265, 269–270
74. Sec. 147.20 (2)
75. 12 Atty Gen. 144; State vs. Lewis 164 Wis. 363
76. State vs. Schaeffer, 129 Wis. 459, 467
77. 24 Atty. Gen. 108
78. 18 Atty. Gen. 289; 21 Atty. Gen. 476
79. Sec. 147.20 (3)
80. 18 Atty. Gen. 289
81. 26 Atty. Gen. 378
82. Sec. 147.20 (5)
83. 2 Atty. Gen. 571
84. Sec. 147.20 (4); 22 Atty. Gen. 942
84a. Sec. 147.20 (7)
85. Sec. 147.195
86. Chap. 411, Laws of 1953
87. Sec. 147.185 (6)
88. Sec. 147.185, Statutes 1951
89. Ibid
90. Sec. 147.185 (6)
91. 28 Atty. Gen. 685–686
92. Chap. 411, Laws of 1953; Sec. 147.185
93. Sec. 147.185 (1) (a)
94. Sec. 147.185 (1) (b)
95. Ibid
96. Sec. 147.185 (1) (a)
97. Sec. 147.185 (1) (b)
98. Sec. 147.15 (1)
99. Sec. 147.17 (3)
100. Sec. 147.17 (6)
101. Herzog, Medical Jurisprudence, Sec. 121; and Arnold v. Schmitt 155 Wis. 55, 61
102. 10 Atty. Gen. 837; 29 Atty. Gen. 148
103. 14 Atty. Gen. 231; 18 Atty. Gen. 6; 19 Atty. Gen. 594; 21 Atty. Gen. 137, 163
104. 29 Atty. Gen. 148, 153
105. Sec. 154.04; Sec. 154.03
106. Sec. 154.01 (1)
106a. Bill 345, A., 1961 Legislature
107. Sec. 154.01 (2)
108. Sec. 147.23 (2)
109. Sec. 147.23 (3)
110. Wisconsin Administrative Code, Chir. 1.14
111. Ibid
112. Sec. 153.03 (1)
113. Sec. 147.01 (2)
114. Sec. 153.01 (1)
115. Sec. 153.01
116. State ex rel Harris vs. Kindy Optical Company, 235 Wis. 498, 501
117. Sec. 153.02 (1)
118. Sec. 153.02 (2)
119. Sec. 153.01 (2)
120. Sec. 147.13 (6)
121. Sec. 147.21
122. Sec. 147.205 (1)

SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

The sale of contraceptives and abortifacients or articles appropriate to that use and sold with the intention that they be so used, is prohibited by Section 151.15 of the Wisconsin Statutes to all persons other than a physician or pharmacist duly licensed in this state. In no event may such article, drug, or preparation be sold to any unmarried person.

Prohibited also is the advertising or displaying of such articles for sale, or the manufacture, purchase or possession of a machine or device appropriate for vending contraceptives or abortifacients.

Violation of the provisions of this statute subjects the violator to a fine of one hundred dollars to five hundred dollars ($100 to $500), or imprisonment in a county jail not to exceed six months, or both.

Reference: Wisconsin Statutes, 1961, Section 151.15.

ABORTION Protect Yourself

THE WISCONSIN Criminal Code provides a fine up to $5,000.00 or imprisonment up to three years or both for the intentional destruction of the life of an unborn child. The law states that an "unborn child" means a human being from the time of conception until it is born alive. If the life destroyed is that of an "unborn quick child" or of the mother, the imprisonment may be as high as 15 years.

A therapeutic abortion is exempt from these penalties, but only when three specific conditions have been met:

1. The abortion must be performed by a physician.
2. At least two other physicians must advise that the abortion is, or appears to be, necessary to save the life of the mother. Therapeutic necessity must be based on danger to the mother's life, not simply on danger to her health.
3. The abortion must be performed in a licensed maternity hospital, except where emergency prevents.

If you are called upon to treat a woman who has had an attempted or completed abortion:

1. Insist on the presence of at least one other physician (not an associate) before treatment is given.
2. When no other physician is available, insist on a written statement from the patient, in the presence of witnesses if possible, reciting the facts concerning the performance of the abortion and including the name of the abortionist. The necessary treatment should then be given only after the patient understands that the physician may use the statement in the event he later requires it for his own protection.

The above two steps are recognized by the Wisconsin Supreme Court as reasonable precautions before treating a woman who has had an attempted or completed abortion.

Abortion Deaths To Be Reported

Sometimes forgotten is the statutory requirement that all physicians must immediately report knowledge of any death following an abortion. The report must be made to the sheriff, police officer, or coroner of the county in which the death occurs.

Legal counsel for the State Medical Society believes the reporting requirement is intended to apply only to those situations in which the mother dies following an abortion and not to the destruction of a fetus. However, the prudent physician will do well to protect himself by reporting *all* deaths associated with abortion.

REFERENCES

1. Wisconsin Statutes, 1961, Section 940.04
2. Wisconsin Statutes, 1961, Section 966.20
3. *State v. Law*, 150 Wis. 313 (1912)

SPECIALISTS AND GENERAL PRACTITIONERS

Available through Placement Service

The Placement Service of the State Medical Society has registered with it a number of specialists in various fields as well as general practitioners. Contact the Placement Service by writing Box 1109, Madison, Wisconsin.

LAW REQUIRES SILVER NITRATE TO PREVENT INFANT BLINDNESS

The state law requires, and the State Medical Society recommends, the continued use of silver nitrate for the prevention of ophthalmia neonatorum.

Some birth certificates filed with the State Board of Health reveal that Wisconsin physicians are utilizing penicillin as a substitute for silver nitrate. However, professional circles still debate the efficacy of substitutions for silver nitrate. The State Medical Society's Committee on Maternal and Child Welfare believes there is not enough evidence to recommend the use of substitutes. The American Medical Association has expressed the same attitude.

Physicians are warned to use only the 1% solutions of silver nitrate prepared by the State Board of Health and distributed free to each physician through local health officers. The law also requires the physician to use the solution as directed in the prepared instructions.

The use of any substitute for silver nitrate in the prevention of ophthalmia neonatorum subjects a physician to a possible fine of $100. In addition, it may subject him to a suit for malpractice.

Reference: Section 146.01, Wisconsin Statutes, 1961.

The Right to Use the Title "Doctor" in Wisconsin

HISTORICALLY, the title "doctor" has been conferred upon those who have become so well versed in a particular field of knowledge that recognized schools of higher education regard them as qualified to teach. Among the long-established doctoral degrees are those in medicine, dentistry, divinity, law, science, philosophy, letters and music.

TRADITIONALLY, when the treatment of the sick was involved, the title "doctor" has referred to the doctor of medicine.

The right to use the title "doctor" outside the field of treating the sick is not discussed. Obvious examples are doctors of divinity, veterinary medicine, or philosophy, so long as none of them is engaged in "treating the sick," as this term is defined in Wisconsin.

LEGALLY, this concept is generally followed, with Wisconsin statutes and court interpretations becoming rather specific on who may use the title "doctor."

The following is a summary of the present law of Wisconsin as it applies to the right to use the title "doctor" when engaged in "treating the sick" in the state. This is accompanied by brief references to the legal authority supporting the conclusions. It is assumed in each instance that the practitioner has fulfilled licensure or other requirements imposed by Wisconsin law.

Subsections (a) and (b) of Sec. 147.01 (1) of the Wisconsin Statutes, 1959, provide:

> "(a) To "treat the sick" is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof.
>
> (b) "Disease" includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts."

LEGAL AUTHORITY

The following is a summary of the principal statute or court decision which is the basis of the conclusions reached in the chart below and which follows the same order as the chart:

1. **Physician:** The right of a doctor of medicine to use the title without restriction is conferred by Sec. 147.14 (3), Wisconsin Statutes, which provides:

SUMMARY OF WISCONSIN LAW ON USE OF TITLE "DOCTOR"

Practitioner	Unrestricted Right to Public Use of Title:	No Right to Public Use of Title:
1. Physician	X	
2. Osteopath	X	
3. Dentist	X	
4. Podiatrist (Chiropodist)	X	
5. Chiropractor		X
6. Optometrist		X
7. Doctor of Philosophy (when treating the sick)		X

"(3) No person not possessing a license to practice medicine and surgery, osteopathy, or osteopathy and surgery, under s. 147.17, shall use or assume the title "doctor" or append to his name the words or letters "doctor," "Dr.," "specialist," "M.D.," "D.O." or any other title, letters or designation which represents or may tend to represent him as a doctor in any branch of treating the sick."

2. **Osteopath:** Controlled by the above subsection and, therefore, unlimited.

3. **Dentist:** The right of a licensed doctor of dental surgery to use the title without restriction is conferred by Sec. 152.02 (1), Wisconsin Statutes, which provides in part:

"(1) Any person who was lawfully engaged in the practice of dentistry in this state on January 1, 1939, may so continue if he has registered annually. . . . No other person shall practice dentistry in this state, unless he is licensed by the board and annually registered in this state. Any person is deemed to be "practicing dentistry" within the meaning of this chapter who . . . uses or permits to be used, directly or indirectly, for a profit or otherwise for himself, or for any other person, the title or appends to his name the words or letters "doctor," "Dr.," "Doctor of Dental Surgery," "D.D.S.," or "D.M.D.," or any other letters, titles, degrees, terms or descriptive matter, personal or not, which directly or indirectly represent him to be engaged in the practice of dentistry. . . ."

4. **Podiatrist:** (Chiropodist) The right of a registered podiatrist to use the title without restriction is conferred by Sec. 154.01 (2), Wisconsin Statutes as amended by the Laws of 1961. This provides in part:

"(2) No person shall practice podiatry, for compensation, directly or indirectly, or in the expectation thereof, or attempt to do so, or designate himself as a licensed podiatrist, or use the title "D.S.C.", "Dr.", or 'Doctor of Surgical Chiropody", or "Doctor of Podiatry", or "Doctor", or "foot doctor", or "foot specialist" or other title or letter indicating that he is a podiatrist, or otherwise directly or indirectly represent or hold himself out as such, unless registered by the state board of medical examiners . . ."

5. **Chiropractor:** No statute relating to chiropractic authorizes the use of the title "doctor" or initials "Dr." or "D.C." by a chiropractor. The illegality of the use of either the title or the initials "D.C." is based upon Sec. 147.14 (3) quoted earlier in Section 1. of this article, inasmuch as chiropractors "treat the sick."

In *State v. Michaels,* (1938), 226 Wis. 574, the Supreme Court, in an opinion written by Chief Justice Rosenberry, forbade a chiropractor to use the title "doctor." The opinion stated, at pages 578 and 579, that since 1881 the word "doctor" had been restricted by the Wisconsin legislature, and that the right to use the term had become associated with those entitled to practice medicine, surgery, and after 1903, osteopathy.

With reference to the statute regulating chiropractic, which was amended in 1925 to require licensure, the court stated at page 579 of the above opinion:

"The statute was rewritten and revised to make it clear that those practicing chiropractic could not hold themselves out as a doctor or append to their names the title of doctor because, in Wisconsin at least, that would tend to represent them as a doctor authorized to practice medicine, surgery, or osteopathy."

6. **Optometrist:** An optometrist practicing in Wisconsin is *not* entitled to use the word "doctor," the title of "Doctor of Optometry," or the initials "O. D." in the course of his practice. Chapter 153 of the Wisconsin Statutes deals with optometry. It is completely silent on his right to use the title or any variation of it. Authority must, therefore, be sought outside that chapter. In *Nickell v. State* (1931) 205 Wis. 614, at pages 617–618, the Supreme Court held that the examination of human eyes by various mechanical means constituted "treating the sick" under the Wisconsin Statutes. That decision has not been modified by subsequent opinions of the Supreme Court, or by later legislation. The essence of the practice of optometry is the examination of human eyes by such mechanical means. Therefore, the use of the title is controlled by and forbidden under Sec. 147.14 (3), Wisconsin Statutes, quoted in Section 1. of this article.

7. **Doctor of Philosophy:** There is no Wisconsin court decision on the right of a doctor of philosophy to make public use of his title when treating the sick. It is clearly controlled and prohibited by the provisions of Sec. 147.14 (3) quoted in Section 1. of this article.

As the Rosenberry opinion stated so appropriately as to the use of the title "doctor" by chiropractors in the *Michaels* case, cited in Section 5. of this article, at page 580 of that decision:

"The title does not aid him in the treatment, it merely aids him in securing the confidence of prospective patients and in inducing people to apply for treatment."

In the somewhat earlier case of *Corsten v. Industrial Commission* (1932), 207 Wis. 147, the court concluded its discussion of the meaning of Sec. 147.14 (3), quoted earlier, with the following sentence which appears at page 149 of the decision:

"Thus these names and letters may be applied only to those who are licensed as physicians to practice medicine and surgery, and conversely those to whom the names and letters may not be applied are not physicians."

Main entrance to University Hospitals

University Hospitals GUIDE for Referring PHYSICIANS

Reprinted from the University of Wisconsin Handbook published in 1962

FOREWORD

The University Hospitals, an integral division of the University of Wisconsin Medical Center, includes the State of Wisconsin General Hospital, Wisconsin Orthopedic Hospital for Children, Infirmary, Bradley Memorial Hospital and the Cancer Research Division.

ADMISSION REQUIREMENTS

Emergencies

To admit an emergency case to University Hospitals, the physician should call the admissions office (Al 6–6811, Ext. 332) and signify that the case is an emergency. Available facilities insure that emergency cases will be quickly treated. A brief medical report should accompany the patient.

Elective Admissions

In addition to the referral of a practicing physician, there are several admission requirements for each patient, including outpatients, who will use the services of University Hospitals.

First, a medical report on the patient is required from the referring physician. This report should include the chief complaint; a brief history of the present condition; past medical history of illnesses confining the patient to bed; communicable diseases, including tuberculosis; mental or nervous disorder; previous operations and hospitalization; probable diagnosis; and past treatment for the present condition.

Second, there must also be authorization for the care and treatment of the patient if the county judge, county welfare department, or a private agency is responsible for the patient's medical care.

Third, the referring physician should include social information which may be pertinent to diagnosis or management of the patient.

Fourth, appointment from the University Hospitals for admission of a patient as an inpatient, or to be seen as an outpatient, is necessary prior to the arrival of the patient at University Hospitals.

All requests for admission, inpatient or outpatient, may be directed to: Admissions Department, University Hospitals, 1300 University Ave., Madison 6, Wisconsin. ALpine 6–6811. Extension 332 (Inpatients); Extension 755 (Outpatients)

CHARGES

Inpatient Services

The University Hospitals charge patients a Daily Service Charge for board, room and general nursing care, plus charges for ancillary services, such as laboratory, drugs, x-ray, operating room, etc. The charge depends on the patient's room accommodations.

Following is the Daily Service Charge in effect since August 1, 1961.

Daily Service Charge For Patients Other Than Psychiatry, Newborn, Prematures and Rehabilitation Center

County Rate*	$19.00 per day plus ancillary costs
5 or more bed room	$19.00 per day plus ancillary costs
3 to 4 bed room	$20.00 per day plus ancillary costs
2 bed room	$21.00 per day plus ancillary costs
Single bed room	$23.00 per day plus ancillary costs

Other Daily Service Charges

Psychiatry	$25.00 per day plus ancillary costs
Newborn	$ 6.00 per day plus ancillary costs
Prematures	$19.00 per day plus ancillary costs
Rehabilitation Center	$28.50 per day plus ancillary costs
Orthopedic Hospital	$19.00 per day plus ancillary costs

These rates and charges are scaled to just cover the cost of operating University Hospitals. Approximately $20,000 a day is required to keep the Hospital operating. Since it is a self-supporting institution, University Hospitals must meet these costs from income received through patient services. Charges, therefore, are established each year at the level of projected hospital expenses.

* (State, Special Rate W, Special Rate S, Special State charge. The county is responsible for no more than $15.40 per day under 1961–62 charges for care of patients authorized through the county judge. This includes Daily Service Charge, all ancillaries and professional fees. The State of Wisconsin pays the remainder.)

DIRECTORY for INFORMATION

To Telephone: Area Code: 608
Number: Alpine 6–6811

To Write: University Hospitals
1300 University Avenue
Madison 6, Wisconsin

FOR SPECIFIC DEPARTMENTS:

Administration
Superintendent _____Extension 211
Asst. Superintendent _____Extension 777

Admissions
Inpatients _____Extension 332
Outpatients _____Extension 755

Current Hospital Charges
Business Office _____Extension 245

Patient Classification
Financial Counselor__Extension 250 or 770

Information for:
Interim Reports, Discharge
Plans, Follow-up Services
and Social Security Aids
Patient Control Center
(Adult) _____Extension 246 or 247
(Children) _____Extension 315

General Information
Main Lobby _____Extension 333

Outpatient Services

A registration fee of $5.00 is required for patients being seen for the first time in the outpatient department. Only one such registration fee is required, even though the patient may be seen by referral over a period of years. There are individual charges for those procedures and treatments that are ordered by the physician.

The first two floors of the west half of the Nurses Dormitory are used to house outpatients and relatives of inpatients. Fifteen single rooms are available. Eight of these rooms have adjoining shower and bathroom accommodations and will be reserved for women. Seven rooms have central bathroom and shower accommodations and will be reserved for men. The unit is under the direct supervision of a house mother who lives in the dormitory. One-half of the room and board will be paid by the State of Wisconsin for patients authorized by the county judge.

Send requests for information about current hospital charges and authorization to the Business Office, University Hospitals, 1300 University Ave., Madison 6, Wisconsin. ALpine 6–6811, Extension 245.

PATIENT CLASSIFICATIONS

At the time of admission to University Hospitals, each patient is classified according to his ability to pay for services. A confidential financial interview, or authorization of a county judge, county welfare department, or a private agency indicating the patient's responsibility, will determine the classification.

There are now seven classifications available at University Hospitals, including State, Special Rate W (Welfare), Special Rate S (Sanatorium), Special State, Veteran, Special Rate and Private.

State

Patients are classified as State when they are unable to pay hospital charges or physician's fees, and when their admissions are authorized by county judges. The State of Wisconsin will share the cost of hospitalization with the county. The county will pay one-half of the billed charges or one-half of the previous year's per diem, whichever is less, and the State will pay the remainder. There is no charge for physicians' services, except to the extent that the patient has medical insurance coverage. There is no quota on the number of patients a county may admit.

County judges may also authorize recipients of social security aids for care at University Hospitals, which provides for greater State participation in the patients' medical care. Full hospital charges are met by the State of Wisconsin for patients de-

pendent on the State and authorized by county judges.

Special Rate W

Special Rate W (Welfare) admissions to University Hospitals are authorized by county welfare departments through the Social Security aid programs. The county is responsible for the total hospital charge through federal and state financial participation, but there is no charge for physicians' services, except to the extent of a patient's insurance coverage.

Special Rate S

A patient is classified as Speical Rate S (Sanatorium) when care at University Hospitals is authorized by the county sanatoria. The cost is met by the sanatoria. There is no charge for physicians' services, except to the extent of the patients' medical insurance coverage. Consultation with the thoracic service of University Hospitals is important prior to arrangements for admission.

Special State

A patient is classified as Special State when the Division of Institutions of the Department of Public Welfare authorizes care at University Hospitals for any patients in State Institutions. The State of Wisconsin will share the cost of hospitalization with the institution involved, which will pay one-half of the billed charges, or one-half of the previous year's per diem, whichever is less. Except to the extent of a patient's medical insurance coverage, there are no physicians' fees.

Veteran (V2 or V3)

Special provisions made by law cover the admission of war veterans for care at University Hospitals under the Veteran classification. In addition to the patient's referral by a family physician, the patient must have been a resident of Wisconsin for not less than five years prior to the application for admission. The veteran (V3) or the Wisconsin Department of Veterans Affairs, or the County Veterans Service Commission (V2) is responsible for one-half the billed charges, or one-half of the previous year's per diem, whichever is less. No charge is made for physicians' services. Any and all hospitalization insurance that the veteran holds must be used toward payment of the total hospital charges.

The veteran may elect to be a private patient. As such, he assumes responsibility for all physicians' fees, billed separately by attending physicians. On admission the veteran will be asked to show record of honorable discharge. Veteran preference rates do not apply to outpatient services.

Special Rate

Patients able to assume hospital charges, but unable to afford full physicians' fees, may be admitted to University Hospitals as Special Rate patients on referral of the family physician. There are two types of Special Rate patient: Special Rate, no professional fee; and Special Rate, reduced professional fee.

The medical care of Special Rate patients is the responsibility of the particular medical service to which the patient is assigned following admission to the Hospitals. In the referral statement, the physician should indicate the special need for diagnosis or treatment. He also should indicate that the patient is able to pay the established Hospital charges, but that the payment of full professional fees would be an extreme hardship. When the reduced fee classification is assigned a patient, the active medical staff is authorized to accept on behalf of the staff, the reduced fee for which the patient is liable.

Private

Patients able to assume both hospital charges and physicians' fees may be admitted to University Hospitals on the referral of the family physician as Private patients. A private patient has the choice of attending physicians and is responsible for all Hospital charges. The attending physicians bill patients separately for professional fees.

Request any information regarding patient classification from: Financial Counselor, University Hospitals, 1300 University Ave., Madison 6, Wisconsin. ALpine 6—6811, Extension 250 or 770.

SOCIAL SERVICE AND PATIENT CONTROL CENTER

Social Service

Social counseling is available to patients and their families at the request of the medical staff of University Hospitals. If the request for counseling service is initiated from another source, approval of the medical staff is necessary.

Referring physicians or agencies wishing social counseling for patients may suggest this need in a letter of referral or may communicate directly with the Medical Social Service Department. All patients under care in the Muscular Dystrophy Clinic and the Rehabilitation Center are routinely referred to Medical Social Service.

Since social factors may be important in the medical diagnosis and treatment of many illnesses, referring physicians and agencies authorizing evaluation or treatment at University Hospitals are encouraged to submit social information prior to, or at the time of the patient's admission.

Patient Control Center

An administrative unit of University Hospitals, the patient control center has responsibility for several types of services.

The center performs liaison service between the Hospitals and the county courts, county welfare departments and with divisions and institutions of the State Department of Public Welfare. It also assists all patients at the time of discharge with

regard to medicine, equipment, dressings, plans for special care at nursing homes, sanatoria, and state institutions for mentally ill, and in regard to financial assistance and transportation.

The center also provides assistance to patients with problems of any category with referral to health, welfare and rehabilitative sources as indicated.

All requests for information regarding interim reports, plans for discharge, follow-up services, and social security aid forms may be made to: Patient Control Center, University Hospitals, 1300 University Ave., Madison 6, Wisconsin. ALpine 6–6811, Extension 246 or 247. For social service, write Social Service Department, or call Extension 298.

CONSULTATION SERVICES

Consultation services are performed by University Hospitals throughout the state and nation. Following is a brief description of the various services available at the Hospitals.

Allergy

The Allergy Division has full facilities for the diagnosis and treatment of diseases of known or suspected allergic etiology. In addition to the usual allergic diseases such as asthma, hay fever and dermatitis, the division is interested in drug reactions, violent reactions to insect stings, and other conditions in which a distortion of the normal immune responses is a factor in pathogenesis. It will often expedite the division's diagnostic procedures if the patient omits sympathomimetic or antihistaminic drugs 24 hours before his appointment at University Hospitals. Most patients can be seen in the outpatient service, but inpatient care is available for acute or severe cases. If injection treatment with allergen extracts is necessary, these materials will be supplied to the referring physician.

Cancer Research

The Surgery Department's Cancer Research Division offers diagnostic, therapeutic, educational and special metabolic services for cancer. Facilities are available for outpatient, inpatient and laboratory services. Physicians may refer patients to these services by letter or telephone, which initiates appointment to the appropriate clinic or physician concerned.

All classifications of patients are accepted for outpatient evaluation to ascertain further disposition. The cancer staff utilizes University Hospitals services and specialists in conjunction with complete studies of cancer problems. Close communications are maintained with the referring doctor and a tumor registry follow-up evaluates progress and methods.

Cardiovascular Diseases

Techniques, including right and left heart catheterization, cineangiocardiography, aortography, quantitative techniques for measuring cerebral, renal and coronary blood flow, and renal clearance techniques, including electrolytes, are available for establishing a precise diagnosis and for quantitating degree of disease.

Clinical problems which can be precisely evaluated using the above techniques include acquired and congenital cardiovascular disease in adults and children, peripheral vascular disease, cerebral, renal and coronary vascular disease complicating hypertension, renal disease as an etiological factor in hypertension, clinical problems in fluid retention and renal failure, as well as cardiac and primary pulmonary disease, with or without cardiac complication. Evaluation of adults and children as candidates for surgical treatment of acquired and/or congenital cardiovascular disease is done in the Cardiovascular Research Laboratory.

Dermatology and Syphilology

The Division of Dermatology and Syphilology serves in the diagnosis and treatment of skin cancer, nevi and new growths of the skin in both outpatient and inpatient areas.

In addition, the division is equipped to diagnose and treat fungus diseases and allergic skin problems. Interpretation of skin changes seen in patients with undiagnosed systemic disorders like the so-called collagen diseases, as well as the evaluation of the patient with an unsuspected positive serological test for syphilis, may be of special help.

Equipment for performing superficial x-ray therapy, electrosurgery, cryotherapy, electrolysis and minor surgery is available.

Gynecology and Obstetrics

The department offers complete inpatient and outpatient service in all matters pertaining to gynecology and obstetrics. Facilities are available for special examinations necessary for infertility studies, the diagnosis of endocrine abnormalities, and the diagnosis and management of abnormal uterine bleeding. The department also maintains facilities for consultation and management of all types of genital cancer, both early and late.

Outpatient services are available daily. The multidiscipline female endocrine clinic is held on Wednesday mornings and specializes in menstrual abnormalities, fertility problems and disturbances related to pituitary, adrenal and ovarian dysfunction with or without masculinization.

General Surgery

This service also provides inpatient and outpatient care. The outpatient service is available every day, for twenty-four hours a day for emergency treatment. Patients seen in the outpatient department are either treated or admitted to the Hospital. Service is available in general surgery, chest surgery, surgery of the heart and large vessels, peripheral vascular surgery, chemosurgery, and perfusion technique in the treatment of tumors.

Internal Medicine

The Department of Internal Medicine is equipped to treat, on both the outpatient section and the inpatient section, almost every type of diagnostic and therapeutic problem in the spectrum of general medicine. For example, treatment is offered for arthritis; allergy; infectious, metabolic and endocrine, cardiac, pulmonary, renal, including dialysis with an artificial kidney, hepatic, gastro-intestinal, including small bowel biopsy, psychosomatic, hematologic, and malignant diseases. Facilities for cardiac catheterization, pulmonary function evaluation, various biopsy studies and radio-isotope techniques are available for investigation. Available to manage ambulatory patients are a well established diagnostic clinic and outpatient department.

Integral sections of the medical service are the physical therapy unit and the occupational therapy facilities. The department has an active program of clinical investigation in almost every area. As necessary from time to time and upon completion of the patients evaluation and therapy, the results are reported to the referring physician.

Neurology

Inpatient and outpatient services and special laboratory studies are provided by the Department of Neurology. Both patient services provide complete neurologic evaluation of patients with suspected organic diseases of the nervous system, such as epilepsy, brain tumor, Parkinsonism, multiple sclerosis, headache, spinal chord disease, cerebrovascular diseases and neuritis, as well as rare degenerative diseases of the nervous system. Certain epileptic patients are selected to receive long term free hospitalization. The selection is made on the basis of unusual seizure types for study as cases suitable for experimental drugs.

In the outpatient department special clinics are set up as follows: muscular dystrophy, child neurology, epilepsy, general neurology, cerebral palsy, multiple sclerosis, and Parkinsonism. The special laboratory studies include electroencephalography, special eye examination relevant to the central nervous system, special hearing tests including sound localization tests for temporal lobe diseases, and special studies on spinal fluid such as protein fractionation and enzyme studies in the cerebrospinal fluid.

Neurological Surgery

The neurosurgery service is well equipped for the diagnosis and surgical treatment of various types of illness due to involvement of the brain, spinal cord, peripheral nerves, and the autonomic nervous system. Specifically, the more common conditions suitable for management on this service are as follows:

—Acute head injuries and their various complications, such as epidural and subdural hematomas; depressed skull fractures, etc.

—Chronic head injuries, i.e., residual paralyses, post traumatic headache, post traumatic epilepsy, subdural hematoma.

—Patients with injury to the spinal cord in the period just following the accident. In cooperation with other departments, treatments and rehabilitation of patients with paraplegia.

—Tumors of the brain and spinal cord.

—Congenital anomalies such as hydrocephalus, spina bifida, craniosyntosis in children.

—Peripheral nerve injuries with persisting paralysis.

—Peripheral vascular disease or hypertension, where sympathectomy may be indicated in selected cases.

—Selected cases of Parkinsonism may be benefited by surgical procedures, though they first should be referred to Neurology.

—Intractable pain due to malignancy or other causes such as trigeminal neuralgia and other forms of neuralgia.

—Surgical management of epilepsy due to atrophic lesions as well as brain tumors.

Ophthalmology

The Eye Service presents inpatient services as well as outpatient clinics which are held Monday, Wednesday and Friday, or by special appointment. All types of examinations and medical eye problems are cared for by the service. Patients are evaluated in the outpatient department regarding the need for hospitalization. Post-operative and treatment cases are observed at specified times. The inpatient service includes all phases of medical and surgical ophthalmology, complete study of eye problems, and the treatment of such is carried out or advised. Glaucoma, cataract, retinal detachment, squint, corneal transplants, emergency eye care, and many other phases of ophthalmology are handled by the staff.

Orthopedics

The Orthopedic Service is divided into an adult and a children's unit, both providing inpatient and outpatient care for patients with bone and joint disturbances and other disabilities dependent upon the dysfunction of the locomotor system.

Adult service has emergency care available 24 hours a day, seven days a week. This service is devoted to the care of diseases of the bones and joints for acute, chronic and traumatic disturbances. Included in this service is reconstructive surgery for joints damaged by arthritis, fracture treatment, injuries and diseases of the spine and the treatment of characteristic bone tumors of the adult age. The orthopedic service also provides an amputee clinic where consultation and treatment may be obtained for the amputee who is having difficulty with locomotion as a result of problems with his artificial limb and with muscular control.

The service for children, one of University Hospitals' oldest, is housed in the Children's Hospital. This service provides emergency care seven days a week, and all services are available 24 hours a day.

Particular attention is given to affections of growing bone, growth disturbances, congenital anomalies and disorders, general body mechanics of the growing child, bone tumors and neurogenic affections, chiefly those resulting from cerebral palsy, residuals of anterior poliomyelitis and the muscular dystrophies and atrophies. The service provides complete care of all types of fractures and rehabilitation of the physically handicapped child is paramount. In addition there is a cerebral palsy clinic which makes a survey and directs treatment to the brain damaged child.

The attending staff consists of three full-time orthopedic surgeons and six resident physicians in training for this specialty.

Otolaryngology

The Otolaryngology Service provides complete care in the field of ear, nose and throat, both on an inpatient and outpatient basis. New patients to the department should be seen initially in the outpatient department except in cases of emergency and critically ill patients. Many of these patients can be evaluated and treated as outpatients and do not necessitate hospitalization.

Cases referred for evaluation of their hearing and possible use of a hearing aid are seen in the outpatient department. Complete hearing aid evaluation can then be made by referral to the speech and hearing rehabilitation center after the otologic examination. Pre-school age children with hearing problems are seen in a special clinic by appointment on Friday afternoons. Clinics are held daily, including Saturday morning. On the second Monday afternoon of each month, there is a tumor clinic both for inital evaluation as well as follow-up after therapy. This clinic is held in cooperation with X-ray Therapy.

Pediatrics

The Department of Pediatrics has inpatient and outpatient services available for the care of children with medical and surgical disorders of childhood. The pediatric outpatient clinic offers general pediatric care and can provide day to day supervision and care of children living in Madison and the environs.

Services are available 24 hours a day, seven days a week for the care of acute and emergency pediatric problems through the pediatric clinic. The inpatient services are available for acute and diagnostic pediatric problems.

A pediatric consulting staff of 12 full-time people are available for consultation in specialized cases of child health.

Plastic Surgery

The Plastic Surgery Service offers a weekly outpatient clinic for consultation and examination of referred patients. In addition, a special cleft palate clinic for older children is held weekly. The surgical service offered includes treatment of congenital deformities, facial injuries, surgery of the hand, burns, skin coverage problems, and cosmetic surgery.

Psychiatry, Adult

Admissions to the psychiatric inpatient service are screened to provide optimal care for selected patients. Of assistance in this selection process is the prompt receipt of available information about a prospective patient. This unit renders service in short term psychiatric therapy, usually a month or less, and evaluates psychiatric problems. An additional factor for selection of inpatients is the patient's suitability for usefulness in teaching. Long term inpatient admissions of psychiatric patients are more properly referred to state hospitals.

Psychiatric evaluation and therapy are provided in the outpatient clinic for those patients who live within a driving radius of the Hospital and can be managed as outpatients. Fees are charged according to the patient's ability to pay.

Psychiatry, Child

The Child Psychiatry Service provides outpatient diagnostic and treatment service to children to age 17 and their families in a variety of psychiatric problem areas. These areas may include disturbances in personality growth and adjustment; psychosomatic illness; physical illness with emotional components; childhood psychosis; learning difficulties with an emotional basis; and mental retardation.

A physician must send a letter of referral briefly stating the problem and indicating the patient's address. The parents are sent an application to complete and reports from school and/or other agencies are secured, with parental approval. Appointment dates are sent to the parents at the time the completed application is received. Even though urgent problems are given priority, a waiting period of two to six months frequently is necessary because of the number of referrals.

New patients are seen for diagnostic evaluation on two visits and upon completion of the initial evaluation a summary of our findings, impressions and recommendations are sent to the family physician. Where indicated and geographically possible, ongoing treatment for the child and parents can be provided.

Child Psychiatry has no inpatient service, and children under jurisdiction of any juvenile court in the state or who are already committed to the State Department of Public Welfare or one of its divisions, should be referred to the Wisconsin Diagnostic Center, especially if inpatient services are needed. The staff here includes child psychiatrists, clinical psychologists, psychiatric social workers, public health nurse. Fees are charged according to ability to pay.

Radiology

The section on roentgen diagnosis is equipped and staffed to do all types of roentgen diagnostic

procedures. In addition to standard examinations, equipment is available for such specialized procedures as tomography, kymography, encephalography, arteriography, etc. A rapid film changer is available for angiographic work. An image intensifier is in use and cinefluorographic studies can be done. The department maintains 24 hour emergency service.

The Radiology Department is also fully equipped to handle the treatment of patients suffering from malignant diseases and other conditions. Equipment includes a million volt machine, a 400 KV machine and a 250 KV machine. Approximately 350 mg. of radium is available in low activity platinum needles and plaques plus 340 mc. of radioactive cobalt in tubes and needles and a 50 mc. strontium 90 beta ray applicator. A 5,000 curie radioactive cobalt beam teletherapy unit will be added in the near future.

Rehabilitation Center

The Rehabilitation Center of University Hospitals treats inpatients with severe physical limitations. The services include those of a general health center as well as those required for the broader aspects of rehabilitation. Together with University departments and governmental agencies, every attempt is made to restore the individual to optimal health, evaluate his capacity for returning home or to gainful employment and to assure his restoration to living as productively as his capacity permits. The center is equipped for caring for patients who have respiratory insufficiency and operates a shop for functional bracing of the upper extremity.

Urology

The Urology Service offers inpatient and outpatient care and facilities for special r-ray studies of the entire urinary tract, kidney function tests and cystoscopic examinations. Examples of treatment offered include correction of birth defects of the urinary tract, kidney stones, tumors of urinary tract, prostatic conditions and urological injury.

All requests for information about consultation services may be directed to: Office of the Superintendent, University Hospitals, 1300 University Ave., Madison 6, Wisconsin. ALpine 6–6811, Extension 211.

CAN YOU PRACTICE WITHOUT A LICENSE?

Suppose you are just out of military service. Or you have just arrived in Wisconsin from another state. Dare you practice, either on a temporary or permanent basis, before you get your license?

Suppose you enter practice in association with one or more other physicians. May you practice before your licensing is complete?

Be careful! Your good intentions may be illegal practice. You may be subject to sharp criticism. or worse.

The best advice: Postpone any contact with patients until your Wisconsin licensure is complete.

The next best advice: Be circumspect. Issue no prescriptions over your own signature. See patients only in consultation with your associates who are already licensed. Act only as an apprentice or as a physician's deputy, never as a privately practicing physician.

Reference: Section 147.15 (2), Wisconsin Statutes, 1961.

BLOOD GROUPING TEST FOR IDENTIFICATION

In an illegitimacy action, the trial court may order the mother, child, and alleged father to submit to one or more blood grouping tests to determine whether the defendant can be excluded as the father of the child. The tests may be ordered, however, only after it has been determined that the tests would be relevant to the prosecution by the mother or the defense by the alleged father.

The results of the test are admissible only to prove that the defendant is not the father. Results which show only that the defendant might be the father are not admissible. Such tests must be conducted by a duly qualified physician or physicians each of whom has specialized in the field of clinical pathology or who possess a certificate of qualification as a certified pathologist issued by the American Board of Pathology.

Whenever relevant in a civil action to determine the parentage or identity of any child, person, or corpse, the court must direct any party to the action and any person involved in the controversy to submit to one or more blood tests. The results of the tests constitute conclusive evidence where exclusion is established and are receivable as evidence, but only in cases where a definite exclusion is established.

Reference: Wisconsin Statutes, 1961, Sections 325.23 and 52.36.

Problems of a Physician's Widow

EACH YEAR death comes to some members of the State Medical Society. In every appropriate case, the Society has written the physician's widow seeking to provide assistance during a trying period. The Society, believing the adage that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's widow. Careful preparation for such eventualities cannot only protect the family, but ease its burdens at a trying time.

Following the death of a physician, the widow will be faced with many decisions involving the settlement of the business affairs relating to her late husband's practice. It is of extreme importance that she act upon the advice of an attorney. Where at all practical, it is recommended that the physician acquaint his wife with some of his business affairs during his lifetime, and also acquaint her with his legal and other advisors so that there can be an established working relationship between such advisors and the widow at such time as she is called upon to act. Some of the chief areas of decisions are indicated below.

Case records of patients and malpractice insurance policies of the physician should *not* be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the widow's chief sources of defense. Every precaution should be taken to insure that these records are kept intact and subject to immediate call for such period. The attorney will be able to tell when the records are no longer needed for this purpose.

The widow can expect that the deceased physician's patients will seek care elsewhere unless he had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his patient. In this event it is wise to insist upon a written request from the patient and his new physician. A copy of the record, with a covering letter forwarding the copy may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

Former patients may seek a continuation of medication prescribed by the deceased physician. This should be carefully avoided because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The deceased physician's narcotic license *must* be surrendered as soon as possible along with any supply of narcotic drugs. These should be sent to the U. S. Treasury Department, Narcotics Division, 628 East Michigan, Milwaukee, Wisconsin. Such letter or package should be sent by *registered mail* with a return receipt requested. This type of mailing is the safest way of sending such items.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the widow should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. The deceased physician's records should *not* be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The widow's advisors can best inform her how to set up the sale.

The collection of the deceased physician's professional accounts is another important matter. She should carefully follow her attorney's advice before bringing suit, since a patient can counterclaim for malpractice within three years. Ordinarily it is not desirable for a widow or the heirs to enforce collection by suit within such period. She should also seek legal and accounting advice on how long to retain the financial records of her husband. It is quite possible that his estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

The State Medical Society office is always available for consultation. Though there may be many who urge speedy settlement of a deceased physician's practice, the wiser course is to proceed slowly with competent legal and other advice.

PHYSICIANS EXEMPT FROM JURY DUTY

You don't have to serve as a juror unless you want to. All practicing physicians, surgeons, and dentists are exempt. This doesn't mean that you are disqualified from jury duty. The exemption is a personal privilege which you may claim or waive as you wish.

If you are called to act as a juryman and wish to take advantage of your exemption, appear in court when called and state the cause of your exemption to the presiding judge.

Reference: Section 255.02 (2), Wisconsin Statutes, 1961.

Medical Loans and Scholarships Available to Wisconsin Medical Students

THE COST of a college education is becoming increasingly expensive; consequently, more and more students are finding it more difficult to finance their entire education from their own and their families' resources. Therefore, the availability of scholarships and loans plays an important role in the financial planning of an education. And a medical education is one of the most expensive!

How do medical students meet their expenses? A recent survey* of all U. S. four-year medical schools revealed that well over half of the fourth-year medical students made use of gifts and loans from parents, their own earnings, and (if married) their wives' earnings. More recently, both scholarship and loan programs have been extensively increased. As a result, qualified but needy medical students are now able to secure more financial aid through their medical schools than ever before. But, there is still a shortage of available funds to meet all the approved requests.

Any student qualified for admission to a medical college who has the sincere desire of completing his education may seek financial assistance through loans and scholarships. While scholarships are awarded on a competitive basis to students of ability and promise who need assistance for their educational expenses, loans are granted to students of good academic standing—although not necessarily of scholarship caliber—who are judged needy according to the ordinary standards used for measuring personal and family resources.

Financial assistance to medical students studying within the State of Wisconsin, at either the University of Wisconsin or Marquette University, is available from several sources. Since the availability of funds and the sources are constantly changing, it is advisable to contact the proper school concerned for information and up-to-date verification of facts.

LOANS

Several sources of assistance, either scholarships or loans, are available only to the particular school of the student's choice. However, several long-term loan funds, which can be incorporated into the student's financial planning, are available at both of the Wisconsin medical schools.

State Loan Funds

These loans are granted by the State of Wisconsin to a borrower who must be a resident of the State of Wisconsin attending an institution of higher education within the state. A student can borrow up to $750 per year with an accumulative total of $5,000. Interest is one per cent (1%) from the date of execution of the note and increases to five per cent (5%) commencing on the July 1 following the last day of school attended. A student who obtains loans for more than one school year is given one additional year in the date of maturity for each year an additional loan is obtained. Contrary to popular opinion, the relationship of the financial means of the parents to the student is not a prerequisite or criterion for borrowing. The criteria for borrowing are quite liberal. The State Loan Fund generally has a substantial amount of money available and is a dependable source; however, the student has only one year to redeem his note following his graduation. This requirement has been a specific handicap for the medical student.

Charitable, Educational and Scientific Foundation Funds**

This student loan program was originally established by the State Medical Society of Wisconsin in 1951. With the creation of the Charitable, Educational and Scientific Foundation of the State Medical Society in 1955, this fund was absorbed by the Foundation and is now administered by its Board of Trustees. Due to current limitations of available funds, applicants must be residents of the State of Wisconsin and enrolled at either the University of Wisconsin Medical School or at the Marquette University School of Medicine.

A student seeking a loan must apply through the Dean of the medical school in which he is enrolled. After appropriate review, which includes approval by the Dean, loans may be granted generally in amounts not in excess of $1,000 per year for a total of three years. Exceptions are made in special circumstances. No interest is charged the student until the student is licensed. Interest charged following licensure varies according to length of time involved for repayment. If the note is paid within one year of licensure following completion of internship, the interest charged is two per cent (2%) per annum from the date of the student's licensure. If payment is completed prior to two years of licensure, interest is three per cent (3%) per annum from the date of licensure; and if payment is completed after the expiration of two years

* Conducted by the Committee of Financial Problems of Medical Students of the Association of American Medical College's Continuing Group on Student Affairs.

** A detailed report of Foundation activities, including the student loan program, appeared in the November, 1962, issue of the Journal.

following licensure, the interest charged is four per cent (4%) per annum starting with the date of licensure. If a student should terminate his medical education prior to his licensure, the rate of interest applicable is four per cent (4%) per annum beginning with the date of termination of his education.

All loans that are obtained from this source are secured by a life insurance policy in the amount of $2,000 or the amount of the loan, whichever is greater. A student who receives a loan from the Foundation places himself under no obligation to practice medicine in a predetermined location.

An amount of approximately $10,000 is usually made available to needy medical students each year by the Foundation. Due to a lack of funds, it is not possible for the Foundation to fulfill the requests of all of the qualified students who apply to this source for financial assistance. However, the Foundation is constantly striving to make additional funds available for needy students. It currently has over $80,000 outstanding in loans.

National Defense Loan Fund

The National Defense Student Loan Program was established under Title 2 of the National Defense Act of 1958 and is administered by the United States Office of Education and will operate under the present legislation for a period terminating on June 30, 1966. The University of Wisconsin and Marquette University have made the National Defense Student Loan Program an integral part of their student financial aid programs. A full-time undergraduate, graduate, or professional school student who has a 2.0 or "C" overall gradepoint average and a "C" gradepoint average in his last completed semester is eligible for aid through this source. New or prospective students are eligible to apply without the completion of a semester; however, high school graduates making application must be in the upper 25 per cent of their graduating class. The maximum amount an applicant may borrow during any one fiscal year (July 1–June 30) is $1,000. Accumulated loans during an academic career may not exceed $5,000. A student who is granted a loan may have up to 11 years after he ceases to be a full-time student to repay with interest at three per cent (3%) per annum commencing one year after graduation. At present, loans are restricted to students enrolled in the fields of public education, science, mathematics, engineering, and modern foreign languages. Students enrolled in medical schools qualify for loans through the National Defense Program under the category of science. It should be noted, however, that students enrolled in premedical studies *are not* eligible for assistance through this fund.

Veterans Loans

These loans are made from funds established by the State of Wisconsin and are administered by the Department of Veterans Affairs in Madison, Wis. To be eligible, the borrower must be a Wisconsin veteran and a full-time undergraduate, graduate, or professional student in his final year of school. The veteran must have served 90 days or more during a war period. The student may borrow $375 per semester with an accumulative total not to exceed $1,000. Interest at two per cent (2%) begins on the date that the loan is initiated. Consequently, this type of loan is not too satisfactory for a medical student, particularly if he decides to enter into residency training.

American Medical Association Loan Guarantee Program

All medical students, interns, and residents in good standing who are United States citizens may use this loan plan provided they are enrolled in full-time training at an American medical school or hospital approved by the Council on Medical Education and Hospitals of the American Medical Association. The American Medical Association—Education and Research Foundation makes arrangements with the Continental Illinois National Bank and Trust Company of Chicago to provide money for loans at present. All loans are guaranteed by the AMA–ERF. As much as $1,500 may be borrowed annually from September 1 to August 31. A total of $10,000 may be borrowed over a period of seven years. Total educational loans from all sources may not exceed $15,000.

Applications from medical students should not be submitted more often than once each academic quarter or semester. Interns and residents should not submit applications more often than once every six months. The minimum amount that will be loaned is $400 and loans must be in even multiples of $100. An interim note will be executed for each individual loan.

In general, the program is similar at all levels of medical education—both graduate and undergraduate. In order that the plan operates effectively, medical schools, the banking industry, and the AMA each play a unique but significant role. Medical schools make the details of the plan known and provide application materials while the banking institutions make the loans and the AMA guarantees the loans so that the interest cost is considerably minimized. Loans are made through a combine of large banks who pool financial resources out of which loans are made. All processing and records are provided by the Continental Illinois National Bank and Trust Company so that the greatest possible saving is realized through volume and mechanization. Consequently, the cost of the loan during the interim period of the note according to the present agreement with the bank will be calculated at 5½% simple interest annually. No payment of interest is made during the training period and no compounding charges are made by the bank for accrued interest.

Under the program a new note will be executed each time additional loans are granted to a borrower. This note, known as an "interim note" will include the principal and interest of the previous

note and the principal and interest for the new loan to be granted. Five months after the borrower completes his training, he has the privilege of converting the interim note into a payout note with a specified monthly payment schedule. The payout note will bear interest in the current market not to exceed 3½% add-on rate. If the accumulated amount is less than $7,200, the borrower may choose a level monthly payment of $30 or more. In case a greater amount is to be paid, he may choose the repayment schedule which will provide a 10-year period with small payments (5% of the total annually) for each of the first 3 years, moderate payments, (10% of the total annually) for the next 5 years, 15% of the total amount during the 9th year and the remaining 20% during the 10th year. This plan permits the debt to be retired during the physician's first 10 years of practice. The borrower has the further privilege of prepaying the loan, thus reducing the interest cost.

Some of the advantages of this program are that it creates the opportunity for the student in good standing to borrow up to approximately one-half the cost of a medical education. The total number of students who can be assisted is limited only by the size of the Guarantee Fund. This type of loan costs less than the usual personal bank loan. One of the reasons is that the risk to the lender has been minimized because the AMA–ERF guarantees each interim note and each payout note. The AMA–ERF must maintain at all times a Guarantee Fund of at least 8% of all outstanding notes including principal and interest. Also, the student may prepay his payout notes without penalty. The student may also refinance his payout note with the AMA–ERF guarantee at a bank in a community where he establishes his practice. The length of time over which the student in medical education can borrow is designed to fit the period of time required to complete his educational plans. Contributions to the Guarantee Fund multiply to provide 12½ times their amount in student credit.

University of Wisconsin Loan Funds

University of Wisconsin Medical School Segregated Fund: This fund is administered by the medical school Financial Aid Committee and the funds are limited to medical students only. This fund has a principal at present of approximately $45,000 and is almost entirely loaned out at the present time. Most of the money in this fund is derived from special gifts by individuals to the University for this specific purpose. The availability of funds from this source to students is generally quite limited. The interest on these loans varies from two to three per cent (2–3%) per annum and there is generally no interest charged until after the date of graduation.

University of Wisconsin Student Loan Funds: These funds are available to all students attending the University of Wisconsin. The funds consist of money which has been donated to the University largely by alumni. A full-time undergraduate or professional school student who has completed one full semester and has earned a 2.0 or "C" average in the last completed semester may apply for aid through this source. The maximum amount of money which may be borrowed at any one time by one student is $500 and the total outstanding debt for any one student is $1,500 maximum. Any amount requested over and above $500 must be reviewed by the Student Loan Committee. Repayment is usually made over a period of a year or two following the original loan, and from this point of view it is probably undesirable for many of the medical students. It is the kind of loan a senior medical student with rather major financial problems might use with the thought that it could be repaid after one or two years of postgraduate medical training.

John Darwin Manchester Endowment Fund: Financial decisions regarding loan applications to this fund are made by the medical school Financial Aid Committee. Loans are approved for a period of one year, the total amount loaned to be paid to the recipient in two installments, one at the beginning of each semester. The note is to bear one per cent (1%) interest per annum after graduation from medical school and the interest is to be paid as it becomes due. The notes are to be written for one year and are to be reviewed annually by the Financial Aid Committee. It is assumed that renewal of the note will be granted while the student is in the medical school. If the student is dropped from the medical school the full amount of the loan and interest becomes due two years following the last due date. Following internship, the recipient is expected to provide evidence of his occupation, financial status, and plans for the future to the Financial Aid Committee. The committee then agrees upon a plan of repayment, taking into consideration the financial status of the recipient, educational objectives and other facts. There is no maximum limit to the amount of money available to any one student under this fund. Loans will be made for any legitimate expense, living, education, etc.

Marquette University Loan Funds

A variety of loan funds has been established at the University to aid needy and qualified students. Full-time students are eligible for these loans according to the conditions of each loan fund. Students who wish to borrow from these funds administered by the University are informed of their eligibility by the Financial Aid Officer. Some of these funds include the Mary O'Connor Student Loan for Women students, established in 1932 by the Wisconsin Council of Catholic Women; the Richard Fitzgerald; Dr. Christine Ivanoff; the Kellogg Foundation; and the Milwaukee County Medical Assistants Loan.

The amount of money that may be borrowed and the rate of interest depends upon the restrictions and conditions of the particular loan fund. Ordinarily, interest is not charged for the period the

student is in full-time attendance in college. The average rate is four per cent (4%), and repayment must be made within two years after college graduation. The amount that may be borrowed varies from approximately $200 to $400.

Short-Term Loans: Short-term loans in small amounts (up to $100), payable within 30 to 90 days and bearing no interest during this period, are provided by the University and are available to all undergraduate students for emergencies that might arise. This source of assistance can prove to be an excellent aid to the premedical student who suddenly finds himself faced with an unexpected emergency.

Dr. Bart Jewson Emergency Loan Fund: An amount of $1,300 was recently established by the family and classmates of Doctor Jewson for loans to needy medical students.

Dr. John S. Hirschboeck Educational Loan Fund: This fund was established in November of 1962 by the Faculty in honor of Doctor Hirschboeck on the occasion of his fifteenth anniversary as the Dean of Marquette University School of Medicine. An amount of approximately $5,000 has been donated to this fund for loan purposes.

Student Emergency Loan Fund: The Student Emergency Loan Fund was established in 1956 by the Marquette Medical Alumni Association for students in any of the four years of medical school.

Aid from Private Foundations for University Students

Students who cannot qualify for any of the above mentioned loans may contact the following private loan sources to secure loan information and applications for an educational loan.

Eddy Loan Fund: The student must be a United States citizen and have completed two years of work in an accredited university or college. Write Thomas M. Thomas, 504 Broadway, Suite 106, Gary, Ind.

Stephens Brothers Foundation, Inc.: The student must be a male senior or a graduate student who will complete his education in the present school year. He must be a United States citizen, resident or nonresident—$500 maximum. Contact the student loan office of your college or university.

Knights Templar Education Foundation: The student must be a Wisconsin resident in the last two years of school. Contact Knights Templar Education Foundation, 207 East Michigan, Milwaukee, Wis.

SCHOLARSHIPS

Avalon Foundation Award

The Avalon Foundation has included the University of Wisconsin Medical School and the Marquette University School of Medicine as recipients of its financial grants for student scholarships. The grants are an unrestricted supplement to the scholarship funds of each medical school, to be expended for nonrefundable grants to students. It is the intent of the Foundation that the scholarship aid be granted to students on a combined basis of financial need and scholastic attainment. At the University of Wisconsin Medical School this year, 20 students received grants totalling $4,000. This is not a perpetuating type of fund, and once the amount of money alloted is used by the particular medical school, the finances will no longer be available to students in that school of medicine.

University of Wisconsin Medical School Scholarships

Lewis E. and Edith Phillips Scholarship: This scholarship was established in 1956 by a gift from the L. E. Phillips Charities, Inc., and is awarded annually by the Dean to three worthy students who need financial assistance. The amount of each scholarship is about $500.

Edwin L. and M. Etta Rasey Memorial Scholarship: Administered by the Wisconsin Farm Bureau Federation, this $500 scholarship is awarded annually to a needy and deserving student.

Katherine Buerki Scholarship: A scholarship of $500 is awarded in alternate years on the basis of financial need, character, and probable success in medicine.

Joseph Dean Scholarship: A scholarship of $200 is awarded annually to a needy and deserving medical student.

University of Wisconsin Foundation Awards: Two awards of $300 each are given annually to worthy medical students in need of financial assistance.

Borden Award: An award of $500 is given to a member of the graduating class who has carried out undergraduate research in a medical field.

Pfizer Laboratories Medical Scholarship: An amount of $1,000 is awarded annually to a medical student on the basis of academic record and need.

Sheard–Sanford Award: The American Society of Clinical Pathology selects on a national basis the ten best reports on research performed in a department of pathology by a medical student. The amount of each award is $100.

Additional information relative to scholarships and loans administered by the University of Wisconsin Medical School can be obtained by writing to the Student Loan Committee, University of Wisconsin Medical School, Room 522 S.M.I. Auditorium, University Hospitals, Madison 6, Wisconsin. Persons enrolled at the University of Wisconsin who are interested in the National Defense Student Loan Program, the Wisconsin State Loan Program, or the University of Wisconsin Student Loan Program are instructed to consult with the counselors at the Office of Loans and Undergraduate Scholarships, 114 Bascom Hall, Madison, Wis., with regard to their financial problems.

Marquette University Medical School Scholarships

Sarah Chaite Memorial Foundation: Five full-tuition scholarships are available through this source and are usually restricted to sophomores, juniors and seniors who have proven themselves academically.

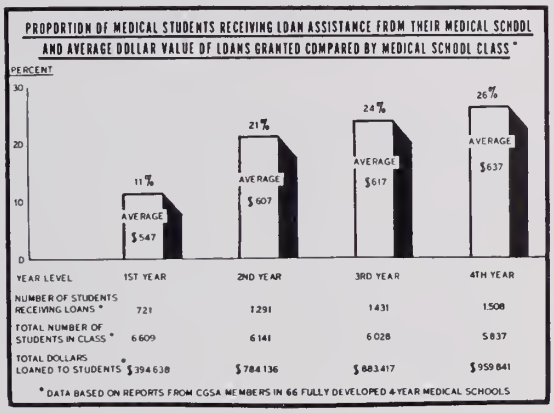
John C. Churchill Memorial Fund: This fund is actually a grant-in-aid for junior students; and a variable amount, usually from $200 to $300, is available for a needy student each year.

Curtis R. Froedert Fund: The fund grants a full-tuition scholarship for an entire year to a needy student who has proven himself scholastically.

Additional information relative to scholarships and loans administered by the Marquette University School of Medicine can be obtained by writing to the Scholarship and Loan Committee, Marquette University School of Medicine, 561 North 15th Street, Milwaukee 3, Wis. Persons interested in either the National Defense Student Loan Program, the Wisconsin State Loan Program, or the University of Marquette student loans are instructed to write to the Financial Aid Officer, Office of Student Affairs, Marquette University, Milwaukee 3, Wis.

SUMMARY

In recent years, scholarships have not been able to supply the amount of financial assistance needed by worthy students, and student educational loans have had to fill the expanding gap. The chart included here illustrates the results of a recent survey conducted by the Committee of Financial Problems of Medical Students of the Association of American Medical Colleges' Continuing Group on Student Affairs. It should be emphasized that the information illustrated here does not include loan assistance provided directly to medical students by



agencies and groups outside the medical schools, e.g., family, local medical societies, etc., although this does include the National Defense Education Act Funds. If the total amount of money loaned to students by the 66 medical schools included in this chart had been projected over the 81 fully developed four-year medical schools in the United States, the amount of loan funds available to medical students during the fiscal year 1961 would have been approximately $3,600,000. However, while the adequacy of the available loan funds varies from school to school, the survey results indicated that the 81 medical schools would have needed an estimated $2,500,000 of additional funds to have been able to grant all of the loan requests made by their students during 1960–61.

It is interesting to note that at the University of Wisconsin Medical School alone, a total of $29,000 was requested for loan purposes the past fall semester while a total of only $13,000 was available for needy medical students.

1962 FEDERAL INCOME TAX NOTES

Three amendments to the federal Internal Revenue Code, enacted in October, 1962, hold special interest for many physicians. They are:

1. New provisions relating to travel and professional entertainment expense deductions for income tax purposes.
2. The deduction from the tax otherwise payable of an investment credit for new business or professional property purchases. Does *not* apply to real estate.
3. Elimination of capital gains treatment on disposition of property used in business or profession, other than real estate.

In addition, the Treasury Department, by revenue ruling, has set out new guide lines for depreciation allowances, intended to permit more depreciation per year through the adoption of shorter lives on various types of buildings and equipment.

The investment credit provision is retroactive to January 1, 1962. The ruling on depreciation allowances is effective for all returns due after July 11, 1962. The other two items have an effective date of January 1, 1963.

Physicians will do well to take up the above points with their tax accountants and attorneys because of their frequent applicability to medical practices and to the ownership of equipment or real estate used in such practices.

How to Complete a Death Certificate

The death of a patient requires at least one legal act by the physician. How he does it can be very important.

MOST death certificates are made and signed by a physician. The reason is obvious—most deaths occur with a physician in attendance. This final act by the physician is not a mere routine.

A death certificate is vital in a number of ways. In Wisconsin a human corpse may not be buried or otherwise disposed of before a proper death certificate is made and signed by a competent person. Burial may not take place without a permit for burial or removal. Issuance of the permit depends on a "complete and satisfactory certificate of death."

Here is what the law requires:

1. The certificate shall be made and signed by the physician last in attendance on the deceased.
2. The certificate must specify the time in attendance, the time the physician last saw the deceased alive, and the hour and the day at which death occurred.
3. The physician must state the causes of death in such a way to show the course of disease or sequence of causes resulting in death, and the duration of each.
4. Indefinite and unsatisfactory terms indicating only symptoms of disease or conditions resulting from disease are not acceptable. A certificate containing only such terms will be returned to the physician for correction and definition.
5. The causes of death which may be the result of either disease or violence must be carefully defined. If violence is the cause of death, its nature should be stated, as well as whether it was accidental, suicidal, or homicidal.
6. In case of deaths in hospitals, institutions, or away from home, the physician shall furnish the information required and state where, in his opinion, the disease was contracted.
7. The cause of death and any other facts required must be stated in accordance with the rules and regulations of the State Registrar.

Whoever makes and signs the death certificate must be acquainted with the facts. There may be instances in which the physician last in attendance does not know the cause of death. He may not possess all the information needed to complete a certificate. As a rule, the attending physician does not find it necessary to make a special investigation in order to prepare a certificate. But when a physician is called in to prepare a certificate for a patient he was not attending, he should not insert the information required without first making whatever investigation he feels necessary.

The local registrar may make and sign the certificate if all three of the following conditions are fulfilled:

1. There have been no attending physicians
2. The person desiring to dispose of the body has made request for a burial or removal permit
3. It is impossible to obtain a physician to investigate the cause of death and prepare and execute the certificate "early enough."

"Early enough" has not been officially interpreted, but it probably means that the local registrar may act in order to prevent an unreasonable delay in funeral ceremonies. If all three conditions are fulfilled, the registrar may make and sign the certificate, utilizing information supplied by relatives of the deceased or other competent lay persons. However, if a physician *may* be obtained he *must* be obtained. Such a physician's services will be paid for by the person seeking disposition of the body. Payment of the physician is reimbursable from the estate of the deceased person as a proper funeral expense.

The coroner may issue a certificate of death:

1. If he has held an inquest on the body
2. Without a formal inquest, if he has investigated a death falling in any of the following specific categories:
   a. Death occurring in a hospital, sanatorium, public or private institution, convalescent home, or the like
   b. Death under unexplained, unusual, or suspicious circumstances
   c. Homicide
   d. Suicide
   e. Death following an abortion
   f. Death due to poisoning, whether homicidal, suicidal, or accidental
   g. Death following accident, whether the injury received was the primary cause of death or not
   h. Death when no physician was in attendance
   i. Death when a physician refuses to sign the death certificate.

REFERENCES

1. Wisconsin Statutes, 1961, Section 69.38–69.41.
2. Wisconsin Statutes, 1961, Section 69.44 (1).
3. 40 O.A.G. (1951) 476.

Drugs Subject to Federal Narcotic Laws

ON JULY 25, 1962, the Treasury Department, Bureau of Narcotics, released a general circular No. 262 specifying drugs which are subject to Federal narcotic laws. This list summarizes and describes generally the narcotics of current interest in the drug trade, classified into their respective A, B, X or M categories. The list, printed below, is intended for use by narcotic officers and others including physicians.

* * *

Categories A and B are taxable drugs or compounds and must bear tax stamps; order forms are required for their transfer and the prescription of a physician for their dispensing. For any taxable drug, compound or preparation within the described limits of a Class B product the druggist may accept a physician's oral or telephoned prescription; all other tax stamped narcotics are Class A products under full control and a written, signed prescription must be in the pharmacist's hands before the drug or preparation may be dispensed.

Groups X and M are exempted preparations and need not be tax stamped. Although both are exempt, the two are distinguished from each other by the degree of exemption. Preparations of either group may be sold without a narcotic prescription, but only for bona fide medical use. Persons buying them for dispensing or resale must be registered (Class V–D) and must supply their registry numbers when purchasing. For Class X preparations records of all sales must be kept by suppliers; for Class M preparations only the original sale by the manufacturer need be recorded. Class X preparations require narcotic export permits for shipment to other countries; Class M preparations may be exported without narcotic export permits.

A narcotic-containing preparation which does not come within the described limits of either Class X or Class M (exempt preparations) is a taxable narcotic of either Class A or Class B.

No basic classes have been established under the Narcotics Manufacturing Act of 1960 for the manufacture of drugs designated thus (@) on the list. Their manufacture is, therefore, at present unlawful and their import is prohibited, except that small quantities may, upon special authorization of the Commissioner, be manufactured or imported for scientific research only.

DESCRIPTIVE LIST OF DRUGS SUBJECT TO FEDERAL NARCOTIC LAWS

CLASS "A" (FULLY CONTROLLED) NARCOTIC DRUGS

(Require a written, signed prescription)

I. OPIUM and its derivatives and compounds, including but not limited to the following:

(a) Raw, granulated, powdered, deodorized OPIUM, tincture of OPIUM, powdered or solid extracts of OPIUM and OPIUM preparations.# *(Basic Class 1)*

(b) Mixed alkaloids of OPIUM and their salts. (Pantopon, Spasmalgin) *(Basic Class 2)*

II. Phenanthrene opium alkaloids, their salts, derivatives and compounds, including but not limited to the following:

(a) ACETYLCODONE (acetyldihydrocodeine), its salts, compounds and preparations.@

(b) BENZYLMORPHINE, its salts, compounds and preparations.@

(c) CODEINE (methylmorphine) and its salts.*# *(Basic Class 4)*

(d) CODEINE-N-OXIDE, its salts, compounds and preparations.@

(e) DESOMORPHINE (dihydrodesoxymorphine-d), its salts, compounds and preparations.@

(f) DESOXYMORPHINE, its salts, compounds and preparations.@

(g) DIACETYLMORPHINE or HEROIN, its salts, compounds and preparations.# (Manufacture, sale, distribution or possession is prohibited in the United States.)@

(h) DIHYDROCODEINE (drocode, Parzone, Rapacodin), its salts, compounds and preparations.*# *(Basic Class 15)*

(i) DIHYDROMORPHINE (Paramorfan), its salts, compounds and preparations. *(Basic Class 28)*

(j) ETHYLMORPHINE (Dionin) and its salts.*# *(Basic Class 10)*

(k) HYDROCODONE (dihydrocodeinone), its salts, compounds and preparations.* *(Basic Class 16)*

(l) HYDROMORPHINOL (14-hydroxydihydromorphine), its salts, compounds and preparations.@

(m) HYDROMORPHONE (dihydromorphinone, Dilaudid), its salts, compounds and preparations. *(Basic Class 13)*

* See Class B for compounds permissible on oral prescription

See Class X for compounds permissible as exempt preparations.

@ Manufacture not authorized; no Basic Classes for these drugs

(n) METHYLDESORPHINE (6-methyl-Δ^6-desoxymorphine), its salts, compounds and preparations.@

(o) METHYLDIHYDROMORPHINE (6-methyldihydromorphine), its salts, compounds and preparations.@

(p) METOPON (methyldihydromorphinone), its salts, compounds and preparations. *(Basic Class 14)*

(q) MORPHINE alkaloid, MORPHINE salts, MORPHINE compounds and preparations.# *(Basic Class 3)*

(r) MORPHINE METHYLBROMIDE, its salts, compounds and preparations.@

(s) MORPHINE METHYLSULFONATE, its salts, compounds and preparations.@

(t) MORPHINE-N-OXIDE (genomorphine), its salts, compounds and preparations.@

(u) MYROPHINE (myristyl benzyl morphine), its salts, compounds and preparations.@

(v) NICOCODINE (6-nicotinylcodeine), its salts, compounds and preparations.@

(w) NICOMORPHINE (nicophine, Vilan), its salts, compounds and preparations.@

(x) NORMORPHINE, its salts, compounds and preparations.@

(y) OXYCODONE (dihydrohydroxycodeinone, Eucodal), its salts, compounds and preparations.* *(Basic Class 17)*

(z) OXYMORPHINE (dihydrohydroxymorphine), its salts, compounds and preparations.@

(aa) OXYMORPHONE (dihydrohydroxymorphinone, Numorphan), its salts, compounds and preparations. *(Basic Class 31)*

(bb) PHOLCODINE (betamorpholinylethylmorphine, homocodeine), its salts, compounds, and preparations. *(Basic Class 32)*

(cc) THEBACON (acedicone, acetyldihydrocodeinone), its salts, compounds and preparations.@

(dd) THEBAINE, its salts, compounds and preparations. *(Basic Class 5)*

III. COCA LEAVES, their alkaloids, derivatives, extracts or compounds, including but not limited to the following:

(a) COCAINE, its salts, compounds and preparations. *(Basic Class 18)*

(b) ECGONINE, its salts, compounds and preparations. *(Basic Class 19)*

(c) TROPOCOCAINE, its salts, derivatives, compounds and preparations.@

IV. MARIHUANA (Cannabis sativa), its derivatives or compounds. (Marihuana is not presently used for medicinal purposes in the United States.)@

V. PETHIDINE (isonipecaine, meperidine, Demerol, Dolantin), its salts, compounds and preparations. *(Basic Class 20)*

VI. Opiates, their salts, derivatives and compounds.

1. Pethidine Group:

(a) ALLYLPRODINE (Alperidine, NIH-7440, RO-2-7113), 3-allyl-1-methyl-4-phenyl-4-propionoxypiperidine, its salts, compounds and preparations. Proclamation No. 3266, December 24, 1958.@

(b) ALPHAMEPRODINE or NU-1932, a-1-methyl-3-ethyl-4-phenyl-4-propionoxypiperidine, its salts, compounds and preparations. Proclamation No. 3229, March 28, 1958.@

(c) ALPHAPRODINE or NU–1196 (Nisentil, Nisintil, Prisiliden), a-1, 3-dimethyl-4-phenyl-4-propionoxypiperidine, its salts, compounds and preparations. Proclamation No. 2851, August 24, 1949. *(Basic Class 21)*

(d) ANILERIDINE (Leritine, Lerinol), ethyl 1-[2-(p-aminophenyl)-ethyl]-4-phenylpiperidine-4-carboxylate, its salts, compounds and preparations. Proclamation No. 3139, June 7, 1956. *(Basic Class 26)*

(e) BENZETHIDINE, ethyl 1-(2-benzyloxyethyl)-4-phenyl-4-piperidinecarboxylate, its salts, compounds and preparations. Proclamation No. 3362, July 29, 1960.@

(f) BETAMEPRODINE or NU-1932, B-1-methyl-3-ethyl-4-phenyl-4-propionoxypiperidine, its salts, compounds and preparations. Proclamation No. 2851, August 24, 1949 and Proclamation No. 3229, March 28, 1958.@

(g) BETAPRODINE or NU-1779, B-1, 3-dimethyl-4-phenyl-4-propionoxypiperidine, its salts, compounds and preparations. Proclamation No. 2851, August 24, 1949.@

(h) DIPHENOXYLATE, ethyl 1-(3-cyano-3, 3-diphenylpropyl)-4-phenyl-4-piperidinecarboxylate, its salts, compounds and preparations. Proclamation No. 3362, July 18, 1960.# *(Basic Class 29)*

(i) ETOXERIDINE (Atenorax, Atenos, Cargetidine), 1-[2-(2-hydroxyethoxy)-ethyl]-4-phenylpiperidine-4-carboxylic acid ethyl ester, its salts, compounds and preparations. August 8, 1961, Vol. 26, Fed. Reg., p. 7760.@

(j) FURETHIDINE, ethyl 1-(2-tetrahydrofurfuryloxyethyl)-4-phenyl-4-piperidinecarboxylate, its salts, compounds and preparations. Proclamation No. 3362, July 29, 1960.@

(k) HYDROXYPETHIDINE (bemidone, oxypetidin), 1-methyl-4-(3-hydroxyphenyl)-piperidine-4-carboxylic acid ethyl ester or 1-methyl-4-metahydroxyphenylpiperidine-4-carboxylic acid ethyl ester, its salts, compounds and preparations. Proclamation No. 2851, August 24, 1949.@

(l) KETOBEMIDONE (Ketogan, Cliradon), 4-(3-hydroxyphenyl)-1-methyl-4-piperidyl ethyl ketone or 1-methyl-4-metahydroxyphenyl-4-propionylpiperidine, its salts, compounds and preparations. Proclamation No. 3074, October 18, 1954. (Production not authorized in United States.)@

(m) MORPHERIDINE (morpholinoethylnorpethidine), 1-(2-morpholinoethyl)-4-phenylpiperidine-4-carboxylic acid ethyl ester or 1-(2-morpholinoethyl)-4-carbethoxy-4-phenylpiper-

idine, its salts, compounds and preparations. Proclamation No. 3214, December 10, 1957.@

(n) NORPETHIDINE (Normeperidine, Pethidine Intermediate-B), ethyl-4-phenylpiperidine-4-carboxylate or 4-phenylpiperidine-4-carboxylic acid ethyl ester, its salts, compounds and preparations. December 21, 1961, Vol. 26, Fed. Reg., p. 12216. *(Basic Class 34)*

(o) PETHIDINE-INTERMEDIATE-A, 4-cyano-1-methyl-4-phenylpiperidine, its salts, compounds and preparations. June 20, 1961, Vol. 27, Fed. Reg., p. 5795.@

(p) PHENOPERIDINE, 1-(3-hydroxy-3-phenylpropyl)-4-phenylpiperidine-4-carboxylic acid ethyl ester, its salts, compounds and preparations. August 8, 1961, Vol. 26, Fed. Reg., p. 7760.@

(q) PIMINODINE (Alvodine, Anopridine, Cimadon, NIH-7590, WIN-14098), ethyl 4-phenyl-1-[3-(phenylamino)-propyl]-4-piperidinecarboxylate, its salts, compounds and preparations. Proclamation No. 3297, June 1, 1959. *(Basic Class 33)*

(r) PROPERIDINE (Gevelina, Ipropethidine, Isopedine, Spasmodolosina), isopropyl 1-methyl-4-phenylpiperidine-4-carboxylate, its salts, compounds and preparations. Proclamation No. 3139, June 7, 1956.@

(s) TRIMEPERIDINE (Promedol), 1, 2, 5-trimethyl-4-phenyl-4-propionoxypiperidine, its salts, compounds, and preparations. August 8, 1961, Vol. 26, Fed. Reg., p. 7760.@

2. Methadone Group:

(a) ACETYLMETHADOL (methadyl acetate), 4,4-diphenyl-6-dimethylamino-3-acetoxyheptane or 6-dimethylamino-4,4-diphenyl-3-acetoxyheptane, its salts, compounds and preparations. Proclamation No. 2851, August 24, 1949.@

(b) ALPHACETYLMETHADOL, a-6-dimethylamino-4,4-diphenyl-3-acetoxyheptane, its salts, compounds and preparations. Proclamation No. 3022, June 16, 1953.@

(c) ALPHAMETHADOL, a-6-dimethylamino-4,4-diphenyl-3-heptanol, its salts, compounds and preparations. Proclamation No. 3022, June 16, 1953.@

(d) BETACETYLMETHADOL, B–6–dimethylamino-4,4-diphenyl-3-acetoxyheptane, its salts, compounds and preparations. Proclamation No. 3022, June 16, 1953.@

(e) BETAMETHADOL (Betametadol), B-4,4-diphenyl-6-dimethylamino-3-heptanol or B-6-dimethylamino-4,4-diphenyl-3-heptanol, its salts, compounds and preparations. August 8, 1961, Vol. 26, Fed. Reg., p. 7760.@

(f) DEXTROMORAMIDE (Palfium, Jetrium, Pyrrolamidol, R-875, SKF-d-5137), d-3-methyl-2,2-diphenyl-4-morpholino-butyrylpyrrolidine or d-2,2-diphenyl-3-methyl-4-morpholino-butyrylpyrrolidine, its salts, compounds and preparations. Proclamation No. 3214, December 10, 1957.@

(g) DIMENOXADOL (NIH-7577, Lokarin), dimethylaminoethyl 1-ethoxy-1,1-diphenylacetate or dimethylaminoethyl diphenyl-a-ethoxyacetate, its salts, compounds and preparations. Proclamation No. 3266, December 24, 1958.@

(h) DIMEPHEPTANOL (Methadol, Pangerin, Amidol, NIH-2933), 4,4-diphenyl-6-dimethylaminoheptanol-3 or 6-dimethylamino-4,4-diphenyl-3-heptanol, its salts, compounds and preparations. Proclamation No. 2851, August 24, 1949.@

(i) DIOXAPHETYL BUTYRATE (Amidalgon, Spasmoxale), ethyl 2,2-diphenyl-4-morpholinobutyrate, its salts, compounds and preparations. Proclamation No. 3139, June 7, 1956.@

(j) DIPIPANONE (Pipadone, Phenylpiperone, Fenpidon, Pamedon, piperidylamidone, piperidylmethadone), 4,4-diphenyl-6-piperidino-3-heptanone, its salts, compounds and preparations. Proclamation No. 3139, June 7, 1956.@

(k) ISOMETHADONE (Isoadanon, Isoamidone), 4,4-diphenyl-5-methyl-6-dimethylaminohexanone-3 or 6-dimethylamino-5-methyl-4,4-diphenyl-3-hexanone, its salts, compounds and preparations. Proclamation No. 2793, July 1, 1948. *(Basic Class 23)*

(l) LEVOMORAMIDE, *l*-3-methyl-2,2-diphenyl-4-morpholino-butyrylpyrrolidine, its salts, compounds and preparations. August 8, 1961, Vol. 26, Fed. Reg., p. 7760.@

(m) METHADONE (Adanon, Amidone, Dolophine, Methadon), 4,4-diphenyl-6-dimethylaminoheptanone-3 or 6-dimethylamino-4,diphenyl-3-heptanone, its salts, compounds and preparations. Proclamation No. 2738, July 31, 1947. *(Basic Class 22)*

(n) METHADONE-INTERMEDIATE, 4,cyano-2-dimethylamino-4,4-diphenyl-butane, its salts, compounds and preparations. June 20, 1962, Vol. 27, Fed. Reg., p. 5795.@

(o) MORAMIDE-INTERMEDIATE, 2-methyl-3-morpholino-1,1-diphenyl-propanecarboxylic acid, its salts, compounds and preparations. June 20, 1962, Vol. 27, Fed Reg., p. 5795.@

(p) NORACYMETHADOL, a-d -3-acetoxy-6-methyl-amino-4,4-diphenyl heptane, its salts, compounds and preparations. October 14, 1961, Vol. 26, Fed. Reg., p. 9515.@

(q) NORMETHADONE (Deatussan, Mepidon, Normedon, Phenyl-dimazone, Ticarda, Veryl), 4,4-diphenyl-6-dimethylamino-3-hexanone, its salts, compounds and preparations. Proclamation No. 3082, February 23, 1955.@

(r) PHENADOXONE or CB-11 (Hepagin, Heptalgin, Heptalin, Heptan, Heptazone, Heptone), 4,4-diphenyl-6-morpholinoheptanone-3 or 6-morpholino-4,4-diphenyl-3-heptanone, its salts, compounds and preparations. Proclamation No. 3139, June 7, 1956.@

(s) RACEMORAMIDE (R-610), d -3-methyl-2,2-diphenyl-4-morpholino-butyrylpyrrolidine, its salts, compounds and preparations. Proclamation No. 3214, December 10, 1957 and August 8, 1961, Vol. 26, Fed. Reg., p. 7760.@

3. Morphinan Group:

(a) DEXTRORPHAN, d-3-hydroxy-N-methylmorphinan, its salts, compounds and preparations. Proclamation No. 2879, March 24, 1950.@

(b) LEVOMETHORPHAN, *l*-3-methoxy-N-methylmorphinan or (-)-3-methoxy-N-methylmorphinan, its salts, compounds and preparations. Proclamation No. 3074, October 18, 1954. *(Basic Class 25)*

(c) LEVOPHENACYLMORPHAN (NIH-7525, RO-4-0288), *l*-3-hydroxy-N-phenacylmorphinan or (-)-3-hydroxy-N-phenacylmorphinan, its salts, compounds and preparations. Proclamation No. 3321, October 12, 1959.@

(d) LEVORPHANOL (Dromoran, Levo-Dromoran, Levorphan, Aromarine), *l*-3-hydroxy-N-methylmorphinan or (-)-3-hydroxy-N-methylmorphinan, its salts, compounds and preparations. Proclamation No. 2879, March 24, 1950. *(Basic Class 24)*

(e) METAZOCINE (methobenzorphan, NIH-7539), 2′-hydroxy-2,5,9-trimethyl-6,7-benzomorphan, its salts, compounds and preparations. Proclamation No. 3266, December 24, 1958. *(Basic Class 30)*

(f) NORLEVORPHANOL (NIH-7539), *l*-3-hydroxynormorphinan or (-)-3-hydroxynormorphinan, its salts, compounds and preparations. Proclamation No. 3266, December 24, 1958.@

(g) PHENAZOCINE (phenobenzorphan, Prinadol, NIH-7519, SKF-6574), 2′-hydroxy-5,9-dimethyl-2-(2-phenylethyl)-6,7-benzorphan, its salts, compounds and preparations. Proclamation No. 3297, June 1, 1959. *(Basic Class 27)*

(h) PHENOMORPHAN (NIH-7274), 3-hydroxy-N-phenethyl-morphinan, its racemic and levorotatory forms (but excepting its dextrorotatory form), their salts, compounds and preparations. Proclamation No. 3297 (June 1, 1959.@

(i) RACEMETHORPHAN, d*l*-3-methoxy-N-methylmorphinan, its salts, compounds and preparations. Proclamation No. 3074, October 18, 1954. *(Basic Class 25)*

(j) RACEMORPHAN (Citarin, Methorphinan, d*l*-3-hydroxy-N-methyl-morphinan, its salts, compounds and preparations. Proclamation No. 2879, March 24, 1950. *(Basic Class 24)*

4. Thiambutene Group:

(a) DIETHYLTHIAMBUTENE (diethibutin, Themalon, diethylambutene), 3-diethylamino-1,1-di-(2-thienyl)-1-butene, its salts, compounds and preparations. Proclamation No. 3139, June 7, 1956.@

(b) DIMETHYLTHIAMBUTENE (aminobutene, dimethibutin, Kobaton, Ohton, Skikiton, Takaton), 3-dimethylamino-1,1-di-(2-thienyl)-1-butene, its salts, compounds and preparations. Proclamation No. 3022, June 16, 1953.@

(c) ETHYLMETHYLTHIAMBUTENE (Emethibutin, ethylmethiambutene), 3-ethylmethylamino-1,1-di-(2-thienyl)-1-butene, its salts, compounds and preparations. Proclamation No. 3022, June 16, 1953.@

5. Others:

(a) CLONITAZENE, 2-(p-chlorobenzyl)-1-diethylaminoethyl-5-nitrobenzimidazole, its salts, compounds and preparations. Proclamation No. 3362, July 29, 1960.@

(b) DIAMPROMIDE, N-[2-methylphenethylamino)-propyl]-propionanilide, its salts, compounds and preparations. Proclamation No. 3377, October 28, 1960.@

(c) ETONITAZENE, 2-(p-ethoxybenzyl)-1-diethylaminoethyl-5-nitrobenzimidazole, its salts, compounds and preparations. Proclamation No. 3362, July 29, 1960.@

(d) PHENAMPROMIDE, N-(1-methyl-2-piperidinoethyl)-propionanilide, its salts, compounds and preparations. Proclamation No. 3377, October 28, 1960.@

(e) PROHEPTAZINE (Proheptazone), 1,3-dimethyl-4-phenyl-4-propionoxyhexamethyleneimine, its salts, compounds and preparations. Proclamation No. 3139, June 7, 1956.@

CLASS "B" (ORAL PRESCRIPTION) NARCOTIC DRUGS
(Authorized for "oral prescription")

1. Isoquinoline alkaloids of opium, or any of their salts.

(a) Narcotine (Noscapine)¢ *(Basic Class 6)*
(b) PAPAVERINE¢ *(Basic Class 7)*
(c) COTARNINE¢ *(Basic Class 8)*
(d) NARCEINE¢ *(Basic Class 9)*
(e) MECONIN@

2. APOMORPHINE or any of its salts, alone or in combination with other active non-narcotic medicinal ingredients. *(Basic Class 11)*

3. NALORPHINE (N-allyl-normorphine) or any of its salts.¢

4. (a) Compounds of CODEINE (methylmorphine), or any of its salts, with equal or greater quantity of isoquinoline alkaloid where codeine content does not exceed eight (8) grains per fluid ounce or one grain per dosage unit. (Copavin, etc.)

(b) Compounds of CODEINE (methylmorphine), or any of its salts, with one or more active non-narcotic ingredients in therapeutic amounts where

¢ See Class M for preparations classified as exempt.

codeine content does not exceed eight (8) grains per fluid ounce or one grain per dosage unit. (Codesal, Codempiral, Edrisal with Codeine, etc.)

5. (a) Compounds of HYDROCODONE (dihydrocodeinone) or any of its salts, with a four-fold quantity of any isoquinoline alkaloid where hydrocodone content does not exceed one and one-third grains per fluid ounce or one-sixth grain per dosage unit.

(b) Compounds of HYDROCODONE (dihydrocodeinone) or any of its salts, with one or more active non-narcotic ingredients in therapeutic amounts where hydrocodone content does not exceed one and one-third grains per fluid ounce or one-sixth grain per dosage unit. (Tussionex, etc.)

6. Compounds of DIHYDROCODEINE, or any of its salts, with one or more active non-narcotic medicinal ingredients in therapeutic amounts where the dihydrocodeine does not exceed eight (8) grains per fluid ounce or one grain per dosage unit.

7. Compounds of OXYCODONE (dihydrohydroxycodeinone, Eucodal, etc.), or any of its salts, with one or more active non-narcotic ingredients in therapeutic amounts where the oxycodone does not exceed two-thirds grain per fluid ounce or one-twelfth grain per dosage unit.

8. Compounds of ETHYLMORPHINE, or any of its salts, with one or more active non-narcotic ingredients in therapeutic amounts where the ethylmorphine content does not exceed one and one-third grains per fluid ounce or one-sixth grain per dosage unit.

CLASS "X" NARCOTIC DRUGS (EXEMPT PREPARATIONS)

(Exempted preparations may be sold without prescription)

1. OPIUM Preparations: containing not more than two grains of opium per fluid or avoirdupois ounce along with therapeutically active non-narcotic ingredients.

2. MORPHINE Preparations: containing not more than one-fourth grain morphine, or any of its salts, per fluid or avoirdupois ounce.

3. CODEINE Preparations: containing not more than one grain codeine, or any of its salts, per fluid or avoirdupois ounce.

4. DIHYDROCODEINE Preparations: containing not more than one-half grain dihydrocodeine, or any of its salts, per fluid or avoirdupois ounce.

5. ETHYLMORPHINE Preparations: containing not more than one-fourth grain ethylmorphine, or any of its salts, per fluid or avoirdupois ounce.

6. DIPHENOXYLATE Preparations: pharmaceutical preparations in liquid or solid forms containing not more than 2.5 mg. diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit.

CLASS "M" NARCOTIC DRUGS (ESPECIALLY EXEMPTED PREPARATIONS)

1. NARCOTINE (Noscapine) Preparations: any pharmaceutical preparation containing narcotine, without limit in quantity, along with either active or inactive non-narcotic ingredients of the type used in medicinal preparations.

2. PAPAVERINE Preparations: any pharmaceutical preparation containing papaverine, without limit in quantity, along with either active or inactive non-narcotic ingredients of the type used in medicinal preparations.

3. NARCEINE Preparations: any pharmaceutical preparation containing narceine, without limit in quantity, along with either active or inactive non-narcotic ingredients of the type used in medicinal preparations.

4. COTARNINE Preparations: any pharmaceutical preparation containing cotarnine, without limit in quantity, along with either active or inactive non-narcotic ingredients of the type used in medicinal preparations.

5. NALORPHINE Preparations: any pharmaceutical preparation containing nalorphine, without limit in quantity, along with either active or inactive non-narcotic ingredients of the type used in medicinal preparations. (Nalline, etc.)

FEDERAL DEDUCTIBILITY OF CERTAIN HEALTH AND ACCIDENT INSURANCE

Under a recent decision *total premiums* paid for health and accident policies which provide indemnity for accidental loss of life, limb, sight or time, in addition to surgical-medical or hospital benefits, are deductible medical expenses for *federal* income tax purposes. Such ruling does not, of course, change the limitation permitting the deductibility only of the excess of medical expenses over 3% of adjusted gross income up to the applicable maximum.

Previously the most that could be deducted on a policy which combined surgical-medical and hospital benefits with time loss or similar coverage was that portion of the total premium which represented an allocation of the surgical-medical or hospital benefits. In the case of the Provident plan carried by members of the State Medical Society, this was $17.00, only a minor part of the total average premium paid by member physicians.

Under the recent decision *total premiums* are deductible even though only *part* of each premium is attributable to surgical-medical or hospitalization benefits.

Professional Liability

Prevention and Insurance

THERE IS no guarantee that sometime, sooner or later, you will be faced with a malpractice suit, whether it is justified or not. How you react and the precautions you took beforehand may save your reputation, protect your pocketbook, and stave off a flood of nuisance suits.

A. PREVENTION

1. Be Alert

Watch your patient's emotional and psychological reactions. Answer his questions in a sympathetic and reassuring manner. Be alert to dissatisfaction, grumbling, and uneasiness of the patient and his family.

2. Keep Thorough Records

Record everything relevant in regard to a patient. Your records give you a place where you can point to and say with confidence—"I know I did advise my patient correctly—here is proof." A few minutes spent dictating a letter to a patient (with a copy for your files) may save hours of time later.

3. Seek Consultation When Indicated

An opinion of another physician in a difficult case shows not only that it was difficult but also that you did not rely solely on your own judgment. It is easier to show your patient or his family afterwards that you examined every possible procedure before treatment.

4. Don't Panic—Just Listen

When the complaint or accusation is made, there is a strong temptation to defend yourself, argue, alibi, explain, or even retaliate. *Don't do it.* Just listen carefully and be thankful you are getting advance notice so you have time to prepare.

5. Speak With Extreme Caution

Anything you say may be held against you. Not long ago a patient threatened a Wisconsin physician with malpractice when her "sprained knee" turned into a long-term disability. Confronted in his office by the patient, the doctor did a quick recheck of the situation and replied, in effect, "You're right. If I'd taken a couple of follow-up x-rays three months ago, we would have caught it." This admission was "manna from heaven" to the patient. Whether or not the doctor's treatment had been good medical practice, his impromptu remark was an admission against his own interest and he thereby forfeited any defense he might have had. The case was settled out of court.

6. Be Quick To Notify Your Insurance Carrier

As soon as you suspect a malpractice suit in the making, notify your malpractice insurance carrier immediately. Also get private legal counsel. Don't wait. Any delay may be disastrous to the preparation of a defense. Adequate defense in the unjust malpractice case is a difficult task. No doubt poor defense has lost many a case. Physicians with little or no knowledge of the law are obviously out of place in attempting to defend themselves. Lawyers with little or no medical knowledge or experience in malpractice cases are not a good bet. In the face of a suit, you will be wise to find the best available expert legal advice.

7. Be Slow To Compromise

Don't be too quick to settle. Many doctors operate on the theory that a small settlement will be less expensive than the cost, publicity, loss of time, and mental and emotional strain involved in the defense. Experience shows that unjust and absurd malpractice claims double and triple in areas where doctors are found to be a "soft touch." The increased number of malpractice claims and the higher insurance rates can be a direct result of the "settle-it-quick" attitude on the part of some doctors. For your sake and that of your colleagues, you should offer determined opposition to any unjustified claims.

8. Collect Your Defenses

At the slightest possibility of a claim, begin to pull together your records, reports, and other evidence which might be required for your defense. *At this point, every shred of recorded evidence becomes mighty important.* But in *no* case should you fill in or otherwise *alter* your existing records in any way.

9. Settle a Meritorious Claim Out of Court

The doctor who is actually guilty of malpractice is not likely and probably should not be allowed to go free of penalty. Let your conscience, not alone your pride, be your guide. Meritorious claims should be settled out of court—preferably *before* a suit has been filed. But never settle without having competent legal advice.

B. PROFESSIONAL LIABILITY INSURANCE

If you are ever sued for malpractice, you will need a good professional liability insurance policy as well as a good defense. Such a policy assures you competent technical aid in the evaluation of your case, the preparation of your defense, the negotiation of a settlement, where appropriate, and

the payment of a verdict should one be rendered against you. Experienced counsel will usually recognize and deal effectively with a groundless claim.

Among the specific elements of an adequate professional liability policy, and questions you need to have answered before knowing that you have adequate coverage, are the following:

1. Is your insurance company well established in the malpractice area?

The State Medical Society and your personal attorney are in a position to answer this. The question is important because the adult you treat may wait for three years before he starts a lawsuit alleging malpractice in your treatment of him today. The infant you deliver today may start his action as late as the day before his twenty-second birthday. The patient who is under mental disability today, or goes under guardianship within the next three years, may have up to a total of eight years in which to determine whether to sue for today's services.

You must also remember that the company that insures you *today* is the company that contracts to protect you when you are sued, and *not* a different company whose policy you may hold at that time.

2. Are your policy limits high enough?

You can never be sure of striking a balance between premium economy and adequate policy limits, but it is better to have more insurance than you need than to need more insurance. Your policy has two types of coverage. The first type assures you of legal investigation and of the defense of your claim, if you have observed the requirements of the policy. The other pays the amount of damages for which you are found liable, or for which you settle, up to the stated limits of the policy.

3. Does your policy allow you, without penalty, claim settlements which seem expedient to the company but not to you?

The importance of such a provision to you depends on which of the two considerations is more important to you. Do you want the claims against you settled or do you want your reputation defended? Even if your policy does give you the power of rejection you must exercise it with restraint based on competent advice since you will also consider the greater damage to your professional reputation if you lose at trial.

4. Does your policy protect you for all the procedures and forms of treatment you use in your practice, and does it cover claims based on defects in any apparatus you use?

Have your personal attorney check your policy for exclusions against any of the above. If you do find gaps, you can probably buy additional coverage for more premium to cover those areas. If a particular company won't issue higher limits to you, a second company may be willing to do so.

5. Does your policy cover your acts which, though outside the immediate scope of your practice, are within the general area of your professional competence and activity?

For example, you may be a proprietor, administrator, or trustee of a hospital. If your policy excludes coverage for such risks, you may want an endorsement or new policy. If you are engaged in some activity where there is doubt in your mind about coverage, the prudent course is to give your insurance company written notice describing the activity and requesting a written commitment which covers or rejects such risk.

6. Does your policy protect you against claims based on acts of other persons?

Not only your own acts, but also the acts of any employees or partners you have, may give rise to malpractice claims against you. *You* will want to make sure that your policy protects you no matter *who* commits the act.

7. Does your policy let the company decide the question of coverage when a claim accuses you of misconduct which, if proved, would not only establish the claimant's case against you but also relieve the company of its legal responsibility to you?

Probably no policy language is completely satisfactory in the area whether the company is able to deny coverage for defense of a suit prior to a verdict. Such a denial would amount to a presumption of your guilt pending proof of the charges of professional misconduct. It is most important that you have independent legal counsel of your own, and not rely entirely on your insurance company. In this area your interests and that of your insurance company may be in serious conflict.

8. Finally, are the "declarations" in your policy correct?

Your needs may differ from those of other physicians. The declarations in your policy not only state your name, the fact that you are a physician, and the cash limits of the company's liability, but also *may* contain some detail about the manner in which you practice. To the extent that they do, they describe the risk that your company agrees to insure. If there is a discrepancy between the facts and what the "declarations" state, you may find you have no coverage when a claim arises. Any errors you find should, therefore, be corrected immediately. Further, any time your practice changes your declarations should also be revised as needed.

In conclusion, the steps you take *now* to prevent malpractice claims, or to have a professional liability policy which genuinely meets your needs, will pay off in the future in a saving of time, money, worry and above all, your professional reputation.

Locum Tenens

For a variety of reasons a physician may have occasion to leave his practice for an extended period of time. The choice of the interim custodian of his practice and the arrangement under which he carries it on are then of very real importance.

IN THOSE cases where a locum tenens is secured, the State Medical Society urges that the arrangements be confirmed by a written contract, drawn with the assistance of a local attorney. In arriving at the terms of such an agreement members should consider these fundamental points:

Licensure

The locum tenens must be licensed in Wisconsin as one entitled to practice medicine and surgery. Membership in a local and State Society is further assurance of his ethical standing and abilities.

Staff Privileges

Association on the hospital medical staff, where necessary, should be arranged. The locum tenens should be apprised of the conditions necessary to a continuation of this association, and his compliance with them should be a continuing condition of the contract.

Malpractice Liability

Malpractice insurance should be maintained by both parties under all circumstances.

Partners, Independent Contractor, or Employe

One of the most important matters for decision is that of determining the relationship under which the locum tenens is to assume management of the office. Your own attorney can best describe the practical aspects of this problem. It is sufficient to say that there is a real distinction between these with respect to liability of the principal party for the acts of the locum tenens, and with respect to his power to bind or otherwise obligate his absent confrere. In deciding this relationship, consideration must necessarily be given to the extent the locum tenens is to control the practice. For example, may he move the office acting upon his best judgment alone? Or may he make such purchases to the office account as his judgment dictates? Are the costs of operation to be a joint burden, and in any event, what are they?

Financial Arrangements

Whether the locum tenens is reimbursed on a salary or drawing basis, arrangements must be made with respect to handling withdrawals, the financial records to be kept, collection policy and obligations of locum tenens with respect to accounts receivable of the physician.

Locum Tenens to Give Entire Time

As an essential provision of the contract, provisions should be made with reference to the amount of time that the locum tenens is to devote to the practice. Is he to give his entire time and not to engage in any business which would detract from his abilities to serve the community professionally?

Costs of Operation

If the salary or drawing arrangement with the locum tenens is to be based on the percentage of net income after payment of operating costs, items of costs should be specified so nearly as can be determined. If the physician should own his own office, it is only proper that a rent basis for use of the office be established, and such items as light, heat, wages, insurance, supplies and equipment and the like should all be taken into consideration.

The physicians must likewise determine their policy with reference to accounting for collections for services rendered prior to execution of the agreement by the departing physician. Are these to be considered income under the contract or are they excluded?

Restriction on Practice After Termination of Agreement

Wisconsin recognizes the validity of clauses restricting practice after termination of a contract of employment. Your attorney may refer to the Wisconsin Statutes (1961) Section 103.465 and the case of *Lakeside Oil Company, Inc. v. Slutsky* (1959) 8 Wis. 2d 157 and the cases cited therein. The rule in Wisconsin requires that a restrictive covenant not to compete after a term of employment should be reasonably necessary for the protection of the legitimate interests of the employer and at the same time should not be oppressive and harsh on the employe or injurious to the interests of the general public. An unreasonable restraint is void and unenforceable even to those parts of the restraint which would constitute a reasonable restraint.

Therefore, great care should be taken when drafting such a clause so as to make the restraint fit within the Wisconsin rule.

Termination

A provision for termination of the contract should be made. At the option of the party a definite date may be selected or termination can depend upon the time when the absent associate returns, or may be of indefinite duration, and terminable upon sixty or more days' notice. In any event it should be stated that failure on the part of the locum tenens to carry out in good faith the provisions of the contract should be cause for termination without notice.

Miscellaneous Matters

Other matters which a physician may desire to pass upon may include questions concerning the handling of certain business and personal matters of the absentee member, as well as the form of stationery, billing head, prescriptions, liquidation after termination of the agreement of accounts receivable arising during the operation by the locum tenens of the practice, care and replacement of medical instruments and the like.

POISON INFORMATION CENTERS

MADISON • Phone AL 6–6811

Call University Hospitals, ALpine 6–6811, and ask for "Poison Center" for information concerning any substance suspected of being poisonous.

MILWAUKEE • Phone DI 4–7100

The Poison Information Center in Milwaukee was established in 1956 through the efforts of The Medical Society of Milwaukee County Subcommittee on Accident Prevention. It is located in Milwaukee Children's Hospital.

EAU CLAIRE • Phone TE 2–6611

The Poison Information Center for physicians in the Eau Claire area is located at Luther Hospital.

GREEN BAY • Phone HE 5–5311

For physicians in the Green Bay area, the Poison Information Center is located at Bellin Memorial Hospital.

KENOSHA • Phone OL 4–5311

The Poison Information Center for physicians in the Kenosha area is located at Kenosha Hospital.

The Poison Information Centers maintain complete information on poisons by commercial name, ingredients, relative toxicity and treatment procedures. Their files are kept current through periodic releases received from the Clearing House for Poison Control Centers in Washington, D.C.

Responsibility of the Physician Conducting Pre-Employment Examinations

THE following question is frequently raised by physicians and those interested in pre-employment physical examinations. The answer is provided by legal counsel for the State Medical Society of Wisconsin.

Question. What are the responsibilities of a physician to an employer for whom the physician is doing pre-employment physical examinations, to reveal to the employer conditions known to the physician to exist (such as epilepsy) but of which the physician would have no knowledge in the course of the examination except by previously acquired information in his capacity as the examinee's personal physician?

Answer. Unless the examinee authorizes the physician to disclose to the employer information acquired by the physician in his professional capacity as the examinee's personal physician, the physician should make no such disclosures to the employer.

Opinion. At first sight this question may appear to present a dilemma, but it does so only if the physician and employer have failed to define the physician's responsibilities with sufficient clarity. It should be made clear to the employer at the outset that the physician will limit his reports to such facts as are revealed to him during the examination itself, and will not include information acquired by the physician while treating the examinee as a patient.

The physician to whom this situation is presented is quite likely to feel disturbed by two apparently conflicting legal obligations:

(1) His statutory and ethical obligation to his patient to refrain from "willfully betraying a professional secret;"
(2) His contractual obligation to the employer to disclose all he might know that bears on the prospective employee's fitness for a particular job.

Actually, the physician has only the first of the above mentioned legal obligations. Even if his contract with the employer contained a specific provision requiring the disclosure without the patient's consent of information acquired in the course of professional treatment, that provision would undoubtedly be held void by any court passing upon it, as being contrary to the public policy implied in the protection of secrecy afforded by Section 147.20 (1) (b) of the Wisconsin Statutes.

The real problem, therefore, is not a legal one. Rather, it is a problem in communications. The employer, quite possibly unfamiliar with the physician's legal and ethical obligations to his patients, might find it difficult to understand how the physician could be so lacking in candor as to fail to disclose all information for which the employer may feel he has contracted. The obvious solution to this problem of communication is to inform the employer, preferably at the time of contracting, that the physician's reports will cover only the information obtained at the time of the physical examination made at the employer's request. If this was not made clear to the employer at the time the physician and employer originally contracted for the pre-employment examinations, the physician would do well to clarify the arrangement at a later date, being careful, of course, to refrain from doing so in such a manner or at such a time that the employer would be likely to suspect that one particular employee had a serious health problem.

Another solution, more drastic than is really necessary, would be for the physician to exclude from the list of those on whom he would make pre-employment physical examinations, all persons who had previously consulted him as patients. Such a solution is recommended only if the physician, in making such examinations, finds it difficult to conduct the examination as if he did not know what actually he does know from prior diagnosis or treatment.

POST MORTEM EXAMINATION

Question: Whose consent is required to permit a physician to conduct a post mortem examination?

Answer: Consent for a physician to conduct a post mortem examination is considered sufficient when it is given by the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin.

If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Reference: Section 155.05, Wisconsin Statutes, 1961.

Your Deadlines and Other "Musts"

Below are some of the deadlines and "musts" of a practicing physician:

TAXES

1. By January 15, 1963, you must pay the final installment of the estimated federal and Wisconsin tax on your 1962 income. This may necessitate an amended declaration by that date if you find that you underestimated 1962 income. A final income tax return for 1962, filed before January 31, 1963, will be treated as the equivalent of an amended declaration as of January 15 for both Wisconsin and federal purposes. Penalties are assessed for certain underestimating of taxes. These penalties and their legal avoidance are discussed in Section 5 below.

2. By January 31, you must:
   (1) File the employer's return of income taxes withheld in 1962 on Forms W–3 (Federal) and WT–7 (Wisconsin).
   (2) Furnish a statement to employees on Forms W–2 (Federal) and WT–9 (Wisconsin) showing wages paid and amount of tax withheld during the calendar year 1962.
   (3) File fourth quarterly return for 1962 of income and social security tax withheld on wages paid employees on Form 941 if:
      (a) The entire tax was not paid by timely depositary receipts for all three months of the preceding quarter; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1962.
   (4) Pay income and social security taxes withheld on 1962 wages of employees if:
      (a) More than $100 was withheld in December, 1962, and not paid to government depositary earlier in January, 1963; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1962.

3. Miscellaneous:
   (1) If the total of federal income and social security tax withheld on employees' wages exceeds $100 a month in each of the three months of the preceding calendar quarter, and payments were made to a government depositary previous to the fifteenth of the next month, the quarterly return on federal Form 941 should be filed on or before the tenth of February, May, August, and November, as the case may be.
   (2) If instructions contained in paragraphs (3) and (4) of Section 2 preceding are applicable to your situation, make similar quarterly payments and returns on April 30, July 31, and October 31, 1963, for the respective preceding calendar quarters.
   (3) If federal income and social security taxes withheld on employees' wages exceed $100 in either the first or second months of each calendar quarter, the amount thereof should be paid to government depositary by the fifteenth of the following month. The amount of such withheld federal taxes for the last month of each quarter may either be paid to a government depositary by the fifteenth of the month immediately following or may accompany the quarterly return if the latter is filed by the end of the month following such calendar quarter.
   (4) If no arrangement has been made with the Wisconsin Department of Taxation, monthly payments of Wisconsin income tax withheld must be made by the 20th day of the following month accompanied by Wisconsin Form WT–6.

4. File your Wisconsin and federal partnership and personal income tax returns as early in 1963 as possible, but no later than April 15. State returns should be filed with the assessor of incomes in the district in which you live, Federal returns with the Director of Internal Revenue, Milwaukee.

5. Estimates of Income; Quarterly Adjustments; Penalties.

The first quarterly estimate of your 1963 income must be shown on Wisconsin and federal declaration forms which have to be filed, together with the estimated tax due, by April 15, 1963. Other installments of the tax are due, together with amendments in the declaration should there be a change upward or downward, by June 15, and September 15, 1963. As to the final payment or amendment of declaration due in January, 1964, follow the alternative procedure described in Section 1 above.

Excluding cases of willful understatement, interest penalties are provided for underestimating and thus underpaying taxes on declaration of estimated income, to the extent that each quarterly installment is under 70 per cent of one-fourth of the tax due for the year, as shown on the filed return. A penalty of 6 per cent computed on the amount of the underpayment from the due date of a particular installment is added to the tax. The penalty can be legally avoided in either of two ways. The first is to base the estimated tax upon the previous year's income at 1963 tax rates and exemptions in force at the time a particular installment is being paid, or to base quarterly payments on the previous year's tax, whichever is the lesser. The second is to follow the so-called "90 per cent rule." This is a rather complicated formula, and each physician who cares to follow it should consult his attorney or tax accountant.

ANNUAL REGISTRATION IN WISCONSIN

1. Register with the Secretary of the Wisconsin State Board of Medical Examiners, 1414 South Park Street, Madison 15, Wisconsin, in the month of January. This registration will be on a form furnished by the Board of Medical Examiners.

ANNUAL NARCOTICS REGISTRATION

1. Register with the Bureau of Internal Revenue, Milwaukee, as required by the federal narcotics law, and pay the annual tax of $1.00 *before* July 1, 1963. You are subject to penalties for overlooking either the registration or the tax.

CHANGE OF RESIDENCE

1. Notify the Director of Internal Revenue, Milwaukee, Wisconsin, to insure the legality of your narcotics license. Penalties are imposed for failure to do this.

REMEMBER TO:

1. Make prompt report to the State Board of Health, State Office Building, 1 West Wilson Street, Madison 3, of cancer cases, communicable diseases and others.
2. File with the city health officer or county register of deeds a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.30 (1), Wis. Statutes.
3. Register with the county judge if you desire reference work on commitment proceedings for persons alleged to be mentally ill, mentally infirm, mentally deficient, inebriate, or drug addicts.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician, or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), Wis. Statutes.
5. Report *immediately* the following deaths, as required by Section 966.20, Wis. Statutes, to the sheriff, police chief, or coroner of the county in which such death occurred:

   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.

e. All deaths due to poisoning, whether homicidal, suicidal, or accidental.
f. All deaths following accidents, whether the injury is or is not the primary cause of death.
g. When there is no physician in attendance.
h. When a physician refuses to sign the death certificate.

FEDERAL AND WISCONSIN UNEMPLOYMENT COMPENSATION LIABILITY

See in this connection the text of the box on page 8 of this issue.

HOW LONG SHOULD YOU KEEP YOUR PROFESSIONAL CASE RECORDS AND X-RAYS?

Here are a half dozen good rules to remember:

1. Keep narcotic and other prescriptions at least two years. If you don't, you face severe penalty—even revocation of your narcotic license. The State Board of Health prescribes the records you should keep on narcotics. Follow its advice, and you will meet the requirements of both the Wisconsin and federal statutes.
2. Retain all other patient records as long as they have any conceivable value, either to the physician or to the patient—and in no event for less than six years. This, you say, could be forever. That may or may not be. Here are some examples:

★ Premature destruction of professional records and x-rays could obviously be a disservice to the patient and result in great harm in many situations.

★ A patient who has not used your services for many years might return specifically because you had once cared for him. Even if a patient seems to be leaving the reasonable vicinity of your service, you may be called upon to provide a succeeding physician with his records.

★ Your records should be retained for that period of time during which the record of treatment and diagnosis may be needed by the patient in the prosecution or defense of a legal action or in the establishment of some legal right. Records are of particular importance to the patient in establishing a service-connected disability claim against the Veterans Administration, in determining the mental capacity in a will contest, in evaluating personal injury in an automobile accident, and in determining the extent of disability resulting from an industrial accident in a claim under the Workmen's Compensation Act.

★ Records are vital for defense in malpractice claims against the attending physician and the hospital, if it is involved. Wisconsin statutes require that one alleging a malpractice must assert that claim by institution of legal action within three years of the occurrence of the alleged event. This applies even to those who may be incapacitated by reason of infancy or insanity. Even when no suit has been filed within three years, the patient may still question the value or quality of the professional service as a defense to an action by the physician to collect fees. A collection suit will not then revive the patient's right to damages, but the lapse of that right will not keep him from arguing that the services were so far below standard as to be noncompensable. Such a collection action must be commenced within six years. Thus, if you think it may be necessary to resort to legal action in the collection of your fee, it would be smart to keep your professional records for at least that six-year period.

3. Keep all pertinent records indefinitely as long as there is a known or threatened legal complication such as a malpractice or collection suit.
4. When a suit is actually brought against you by a patient (or someone acting for him), you must preserve all patient records, including x-rays, laboratory reports, and correspondence, until your attorney advises that in his judgment the time is past within which other litigation that might grow out of the first suit could be brought. This may be some time after the litigation has been concluded.
5. If you should bring a suit against a patient, the same time periods must be carefully observed, leaving the final determination to the judgment of an attorney.
6. Records should be preserved even longer than usual if the case is affected by mental incapacity, infancy, or imprisonment of the patient. Rely on your attorney's advice.

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, by-laws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, by-laws and regulations of the state society.

148.03 (1) Nonprofit plans for sickness care. The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(2) Such plans shall be governed by the provisions of s. 200.26 and by no other law relating to insurance unless such law is referred to in s. 200.26 and no law hereinafter enacted shall apply to such plans unless they are expressly designated therein or refer to such organizations as are responsible for the operation of such plans.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The president, the president-elect, the secretary, the treasurer and the speaker of the House of Delegates shall be ex officio members of the Council, but without the right to vote. Nine of its members shall constitute a quorum.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

* As last amended by the 1962 House of Delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

SEC. 2. The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the Bylaws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

The term "full-paid members," as used in this section, includes regular members of the Society,

life members, affiliate members, associate members, educational members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society* by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society thirty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

* Chapter XI, Section 8 was revised in 1958 to require reporting of delegates by the end of the calendar year. This section editorially revised to conform with 1958 amendment.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its mem-

bers as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and

shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council may, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article IX of the Constitution, and the initial term shall be so established as to maintain the election of substantially one-third of the councilors each year, as provided in Section 2 of said Article IX.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

- A Commission on Scientific Medicine
- A Commission on Public Relations and Communications
- A Commission on Public Policy.
- A Committee on Grievances.
- A Commission on Hospital Relations and Medical Education.
- A Committee Advisory to the Woman's Auxiliary.
- A Committee on Cancer.

Unless otherwise expressly provided in these Bylaws, each of these committees or commissions shall consist of five members, each of whom shall serve for a term of five years, and no person shall serve on any one of the above committees or commissions more than three consecutive terms; nor shall any member serve concurrently on more than one such committee or commission. One member of each of these committees or commissions shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee or commission the original appointments shall be for terms of one, two, three, four and five years, and thereafter for terms of five years each.

The chairman of each of the standing committees, or a member of the committee delegated by the chairman, shall make himself available to the appropriate reference committee of the House of Delegates for the purpose of amplifying or explaining the annual report of the standing committee of which he is a member.

SEC. 2. The Commission on Scientific Medicine shall consist of five *appointed* members and the deans of the two medical schools in Wisconsin and the medical editor of the Wisconsin Medical Journal. Each appointed member shall serve for a period of five years. The Commission on Scientific Medicine shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Commission on Public Relations and Communications shall consist of nine members appointed by the President of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Commission on Public Relations and Communications shall study, make recommendations, and implement approved activities to improve the distribution of medical service to the public. It shall also be responsible for all matters relating to industrial, rural health and safety. The Commission shall direct the public information and health education programs of the Society and shall assist the component societies in the conduct of similar programs. It shall also conduct an internal professional relations program to encourage active participation of all members in the affairs of the Society.

SEC. 4. The Commission on Public Policy shall consist of seven members, and the president, the president-elect and secretary. The commission shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

The committee shall consist of nine members and the terms of one-third of its members shall expire each year, with each member appointed for a term of three years.

SEC. 6. The Commission on Hospital Relations and Medical Education shall consist of nine members, to be appointed by the President, with confirmation by the House of Delegates. As nearly as possible the terms of one-third of the members shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three-year terms.

Its duties shall include the subjects of medical education, the interrelationships of the medical profession to hospital institutions, and all matters pertaining to the general subject of hospitals and the ability of the medical profession to provide quality medical care through their facilities.

The Commission shall be responsible to the Council in the interim between sessions of the House of Delegates, and the Council may assign one or more of its members to serve as liaison between the Council and the Commission.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 9. The Wisconsin Medical Journal shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. *Educational Memberships:* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine. shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 6. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 7. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and Bylaws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a bona-fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the Society.

A member of a component society whose license has been revoked or suspended shall be dropped from membership automatically as of the date of revocation or suspension. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a component medical society in which he holds membership, to the territory of another component of the State Society, shall not be eligible to continue his membership in the first such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and By-laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

When a member in good standing in a component society removes his principal practice outside the borders of this State, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice; provided, the period of such continuing memberships in this State shall cease upon his acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. Each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed

to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and bylaws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service.

CHAPTER XII

SECTION ON MEDICAL HISTORY

Membership in this Section shall be composed of those interested in preserving medical history in Wisconsin. The Section shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Section and shall not exceed $10 per year. The Section is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Section shall be segregated, and expenditures from them shall be made under direction and supervision of the Section, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Section, and displays may be developed by the Section for exhibit at the Society's Annual Meeting and elsewhere.

CHAPTER XIII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIV

SECTION 1. These Bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed.

PLACEMENT SERVICE AIDS DOCTORS AND COMMUNITIES

Do you want an associate? Generalist or specialist? Then call ALpine 6–3101 or write Box 1109, Madison 1, Wisconsin.

The placement service of the State Medical Society has helped many physicians find a new assistant, found promising locations for young practitioners, and brought resident medical service to many communities without a doctor.

Here is how the placement service may be able to help you. The Society maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Usually there are 30 to 50 generalists listed and a total of 80 to 125 specialists in all categories. The Society also maintains a list of physicians and communities offering opportunities to the physician in individual, group, and other types of practice. *The Wisconsin Medical Journal* offers to carry up to one inch of advertising copy for two months without charge when the advertisement is placed by an individual member of the Society. Reasonable rates apply to advertisements by clinics and others.

Physicians who have used the placement service have described it as one of the most effective in the United States. Journal advertising, too, has proved highly successful.

One word of advice: Advise the Society of your needs as soon as possible. Overnight results have occurred, but more time usually means better results.

PRINCIPLES OF MEDICAL ETHICS of the AMERICAN MEDICAL ASSOCIATION

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Adopted June 7, 1957

STATE MEDICAL SOCIETY OF WISCONSIN

330 EAST LAKESIDE STREET

MADISON 1, WISCONSIN

The "Home" of the State Medical Society on the south shore of Lake Monona houses the Wisconsin Medical Journal, the Society's Blue Shield plan, general administrative offices, dining room, meeting room, and Council room. Nearly 200 committee and other meetings are held here annually.

Services to Members

Health Educational Activities

Voluntary Health Agency Contacts

Medical Student Loans

Grievance Services

Museum of Medical Progress

Executive Office Services

The Wisconsin Medical Journal

Life Insurance

Disability Income Protection

WPS Protection

Open Panel Program under Workmen's Compensation

Postgraduate Education Programs

Physician Placement

Medico–Legal Consultation

Public Relations

Legislative Representation

Governmental Agency Contacts

Medical Economic Advice

Members, State Medical Society of Wisconsin*

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Weihe, A. R.

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Algoma:
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March, J. F.
Pudleiner, H. G.
Stiehl, C. W.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

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Byrne, W. R.
Dasler, H. A.
Ford, K. K.
Marra, M. G.
Whitlark, F. L.

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Osicka, S. R.

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Garritty, J. E.
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McKenna, J. E.
Moore, G. E.
Seilin, Josef

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Hauch, F. M.
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Hegner, G. T.
Huberty, F. J.
Kagen, M. S.
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Konz, S. A.
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Luther, T. W.
MacLaren, J. B.
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McCanna, P. R.
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Reuter, M. J., Jr.
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Zeiss, E. J.

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Larson, H. H.
Merrill, W. G.
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Prentice, J. W.
Sandin, H. V.
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Stanley, R. A.
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Thieda, E. S.

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May, J. A.
Olson, C. A.
Sargeant, G. M.
Torkelson, L. B.

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Ruppenthal, K. P.

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Edwards, A. C.
Hannan, K. D. L.
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Pearson, C. R.
Pischke, E. F.
Siebert, J. T.

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Macmillan, D. G.
Saydjari, M. S.
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Whaley, R. C.

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Koch, J. C.
Schmidt, E. M.
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Slevers, D. J.
Stone, G. C.
Taugher, V. J.

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Raschbacher, J. L.

Birnamwood:
Damp, O. E.

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Krohn, Eugene
Krohn, J. I.
Krohn, Robert
Marks, J. R.
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Thurow, R. M.

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Schneider, O. M.

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Murphy, P. W.

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McNamee, J. R.
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Corbet, R. H.
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Hoffman, J. R.
McKenzie, J. R.
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Van Liere, J. D.
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Schoeneman, R. H.

Butternut:
Boldt, R. E.

Cadott:
Bowe, C. T.
Haines, B. J.
Zenner, C. E.

* As of December 31, 1962.

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Nemec, George, Jr.

Campbellsport:
Graves, R. H.
Hoffmann, L. A.

Casco:
Kerscher, E. J.

Cashton:
Mauel, N. M.

Cassville:
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Katz, H. J.
Kippenhan, J. E.
Misch, Allen

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Humke, K. R.
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Knauf, R. E.

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Brown, F J.
Graber, R. E.
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Hatleberg, E. A.
Henske, W. C.
Kemper, C. A.
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Sazama, F. B.
Sazama, J. J.
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Larson, Owen E.
Topp, C. A.

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Meili, E. A.

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Koch, James W.
Pfefferkorn, E. D.

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Graner, L. H.

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Poser, R. F.
Shearer, C. E.

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Moffet, D. V.
Rathert, Burton S.

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Lund, R. E.

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McGreane, N. A.
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Olson, Lyle L.
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De Forest:
Grinde, J. M.

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Wade, Chester

Delavan:
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Henke, S. L.
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Miller, G. E.
Moberg, T. D.
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Walter, Wm.
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Wishart, J. H.
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Schulz, H. A.

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Dailey, P. J.

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Rawlins, J. A.
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Whitaker, P J.
Zurheide, H. J.

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Springer, F. A.

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Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Gray, Roger S.
Sorkin, S. S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Bailey, M. A.
Howell, E. C.
Shields, C. H., Jr.

Fond du Lac:
Becker, N. O.
Bissegger, Arnold
Borsack, K. K.
Cerny, F. J.
Charles, J. E.
Cullen, R. E.
Flanagan, C. M.
Gardner, L. C.
Guth, H. K.
Hagel, Hans
Hitselberger, J. F.
Huebner, J. S.
Hutter, A. M.
Keenan, L. J.
Kendell, W. G.
Kief, H. J.
Koll, J. H.
Leonard, C. W.
Liewen, B. E.
Mauthe, Howard
McCormick, D. W.
McCullough, James C.
McCullough, John C.
McLane, Hugh J.
Myers, W. E.
Nemeth, Charles
Pallin, Josephine N.
Parrish, J. G., Jr.
Pawsat, E. H.
Peterson, C. R.
Rupple, J. H.
Schroeder, R. W.
Shahrokh, D. K.
Sharpe, H. R.
Sharpe, H. R., Jr.
Sharpe, J. J.
Smith, D. A.
Smith, E. V., Jr.
Steube, R. W.
Swan, J. C.
Theisen, S. A.
Thomas, H. R., Jr.
Twohig, D. J.
Twohig, D. J., Jr.
Vetter, E. W.
Vrtilek, M. R.
Waffle, R. L.
Waldschmidt, W. J.
Wier, J. S.
Wojta, W. C.
Yockey, J. C.

Footville:
Sargent, C.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Aufderhaar, H. W.
Gruesen, F. A.
Gueldner, L. H.
Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Maloney, C. G.
Russell, J. C. H.
Voytek, J. J.

Fox Point:
Martin, D. H.
Peters, L. M.
Sibberman, Jack
Thompson, L. H.

Frederic:
Andrews, W. C.
Fischer, W. A.

Fredonia:
Wallestad, P. W.

Fremont:
Gloss, A. J.

Galesville:
Alvarez, R. L.
Moen, C. B.
Rohde, E. P.

Genoa City:
Dekker, Cornelis

Germantown:
Fox, T. C.

Gillett:
Klutzow, F. W.

Glendale:
Brand, W. D.
Brazy, R. R.

Glenwood City:
Limberg, A. W.
Limberg, P. W.
McCusker, C. F.

Grafton:
Pelant, K. F.
Seidl, J. A.

Grantsburg:
Cutshall, R. A.
Hartzell, R. L.

Green Bay:
Angus, D. C.
Austin, S. D.
Benkendorf, Charles
Beno, T. J.
Blackburn, M. D., Jr.
Boersma, J. J.
Bolles, C. S.
Brusky, A. H.
Brusky, E. S.
Brusky, S. F.
Burdon, T. S.
Caffrey, J. F.
Christensen, P. D.
Clark, E. V., Jr.
Cook, F. D.
Crawford, C. W.
Danaher, H. H.
Denys, G. F.
Denys, K. J.
Dettmann, J. E.
Dupont, A. J.
Edelblute, L. H.
Erickson, M. R.
Falk, M. J.
Forbes, K. A.
Ford, J. L.
Ford, W. W.
Freedman, A. L.
Goelz, J. R.
Grace, J. B.
Griggs, S. L.
Guthrie, J. M., Jr.
Hagerty, W. T.
Haines, A. W.
Halloin, J. E.
Hammes, D. A.
Hart, L. E.
Heitzman, H. H.
Hitch, O. M.
Hoegemeier, H. W.
Icks, K. R.
Jaques, D. A.
Jensen, R. E.
Johnston, R. E.
Kalina, B. F.
Kaufman, J. E.
Killeen, E. R.
Killins, J. A.
Killins, W. A.
Kispert, R. W.
Kuehl, F. O.
Kuhs, M. L.
Kulkoski, Bernard
LaFlare, J. P.
Leicht, T. R.
Le Mieux, G. E.
LeTellier, M. S.
Levitas, I. E.
Lynn, T. E.
Mackey, J. P.
MacMullen, Wallace, II
McCarey, Arthur J.
McCormick, R. A.
McGuire, G. E.
McNeal, W. E.
Mickle, K. C.
Miller, L. C.
Milson, B. I.
Milson, Louis
Mokrohisky, J. F.
Myers, R. L.
Nadeau, E. G.
Nadeau, George
Nellen, J. W.
Neu, V. F.
Ottum, J. A.
Oudenhoven, R. C.
Quigley, L. D.
Robb, J. J.
Rose, R. J.
Rothe, C. A., Jr.
Sandmire, H. F.
Schibly, W. J.
Schmidt, R. T.
Schultz, J. H.
Sehring, F. G.
Shea, D. W.
Shinners, G. M.
Smith, C. C.
Stauff, G. R.
Stiennon, O. A.
Stoll, W. M.
Sullivan, Donel
Theiler, G. J., Jr.
Theisen, J. K.
Thompson, L. L.
Troup, R. H.
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Urban, Frank
Warpinski, M. A.
Wochos, R. G.
Wunsch, C. A.
Zucker, K. L.

Greendale:
Brown, R. J.
Grosshandler, S. L.
Kuglitsch, E. F.
Onderak, E. P.
Stubenrauch, G. O.

Greenfield:
Kozina, T. J.

Green Lake:
Leininger, A. T.

Greenwood:
Olson, W. A.

Gresham:
Litzen, F. L.

Hales Corners:
Asinas, I. L.
Beil, E. J.
Czajka, J. J.
Damiano, N. F.
Joseph, W. A.
La Susa, T. J.
Pierce, D. F.
Rath, E. K.
Richter, A. M.
Sortor, R. F.
Wolf, R. C.

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Arrambide, George
Hoffmann, J. G.
Hoffmann, W. C. P.
Kern, T. J.
Lehmann, F. W.
Monroe, M. E.
Quackenbush, E. C.
Quandt, V. V.
Sachse, F. W.

Hartland:
Chambers, R. K.
Ridley, J. F.
Samuelson, Clarence

Hayward:
Baertsch, L. M.
Callaghan, D. H.
Krueger, E. R.
Rosman, H. K.
Sahs, M. H.
Wyant, M. E.

Hazel Green:
Klein, G. J.
Farbstein, M. E.

Hillsboro:
Boston, T. E.
Sanford, L. L.

Hollandale:
Marshall, S. B.

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Karsten, F. A.
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Schulz, N. H.
Schutz, W. J.

Hortonville:
Bergwall, J. G
Towne, W. H.

Hudson:
Anderson, M. G.
Bourget, G. E.
Cornwall, M. A.
Hopkins, G. J.
Timp, L. F.

Hurley:
Martinetti, D. J.

Hustisford:
Goetsch, O. F.

Independence:
Meyer, C. F.

Jackson:
Albrecht, J. E.

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Baumgartner, M. M.
Baylon, V. A.
Betlach, Dorothy M.
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Clark, W. T.
Dodge, R. K.
Donkle, M. J.
Farnsworth, R. W.
Fitzgerald, G. P.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Gredler, G. P.
Gutmann, G. E.
Hansen, T. R.
Hartlaub, E. S.
Holland, R. A.
Koch, V. W.
Levin, Harland
Llewellyn, M. B.
McGuire, W. H.
McNichols, E. F.
McSweeny, A. J.
Metcalf, G. S.
Nash, C. B.
Neeno, Katsumi
Nolta, R. T.
Nuzum, T. O.
Odland, P. K.
Otterholt, E. R.
Overton, R. S.
Pember, J. F.
Peterson, Geo. H.
Purdy, M. F.
Rau, Esther L.
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Russo, F. R.
Sabado, E. F.
Schroder, John R.
Schroeder, Jack D.
Sholl, P. R.
Simonsen, H. W.
Smith, D. A.
Snodgrass, H. M.
Tarrasch, Hertha
Thomas, G. L.
Tordoff, J. J.
Vogel, T. L.
Whereatt, R. R.

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Brewer, J. C.
Busse, A. A.
Quandt, C. E.
Quandt, R. W.

Johnson Creek:
Wendt, F. A.

Juneau:
Heath, H. J.
Haessly, F. G.

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Bachhuber, A. E., Jr.
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Behnke, G. A.
Boyd, G. L.
Cherkasky, Simon
Jeffrey, J. S.
Russo, J. G.
Skibba, J. P.

Kenosha:
Altman, J. S.
Ambro, P. J.
Andre, E. F.
Armstrong, G. F.
Ashley, R. W.
Balciunas, V.
Barnes, E. H., III
Bilak, R.
Binnie, Helen A.
Bjork, H. A.
Block, R. M.
Bode, M. J.
Bonell, B. T.
Burhani, A. W.
Burnett, R. G.
Capelli, P. A.
Conzelman, D. R.
Creighton, L. H.
Creswell, C. M.
Currie, R. E.
Davin, C. C.
Davis, D. W.
DeFazio, S. F.
Donnell, W. S.
Duncan, J. T., Jr.
Fai, L. L.
Garren, J. T.
Gerol, A. Yale
Goldstein, D. N.
Graves, J. P.
Hatfield, M. E.
Hauschild, W. A.
Hill, B. Spalding
Holt, S. H.
Horsley, D. B.
Kappus, H. C.
Kent, L. T.
Kleinpell, W. C.
Lipman, W. H.
Lokvam, L. H.
Lutz, J. J.
Mayfield, A. L.
Meeter, U. L.
Milliken, L. D., Jr.
Morrow, C. A.
Mudge, W. A., Jr
Olsman, Louis

Pearson, J. B.
Pechous, C. E.
Pechous, C. E., Jr.
Pechous, Lillian
Peterson, C. E.
Powell, R. A.
Rafferty, H. P.
Randall, A. J.
Rattan, W. C.
Rauen, L. M.
Richards, J. N.
Ruehlman, D. D.
Rullo, A. F.
Sattler, C. A.
Schlenker, L. T.
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Siegel, Morris
Sipos, Stephen
Swift, W. J., Jr.
Turner, Lewis, III
Weber, G. R.
Welsch, R. G.
Whetstone, O. H.
Williams, F. C., Jr.
Wood, Fredrick, Jr.

Kewaskum:
Edwards, R. G.

Kewaunee:
Lanier, A. S.
Lanier, Patricia A.
Nesemann, R. M.
Wits, E. W.

Kiel:
Nauth, D. F.
Theiler, A. C.
Twohig, G. J.

Kimberly:
Curtin, D. W.
Gage, Ralph S.

Kohler:
Gascoigne, C. C.
Rowe, D. M.

La Crosse:
Aiken, R. E.
Alvarez, U.
Anderson, E. M.
Anderson, N. P.
Anderson, P. D.
Bach, A. C.
Brailey, A. G., Jr
Britt, A. G.
Buchman, D. M.
Carlsson, E. S.
Cejpek, K. O.
Cook, A. A.
Copps, S. A.
Corser, D. H.
Daley, D. M.
Dalton, R. M.
Dietz, P. C.
Doyle, D. F.
Durst, J. B.
Egan, G. J., Jr.
Egan, J. F.
Ellenz, G. B.
Ernst, F. W.
Fisher, A. L.
Fox, J. C.
Gallagher, F. J.
Gallagher, W. B.
Gatterdam, P. C.
Getz, Kaare
Gilbert, R. L.
Gilles, Paul L.
Gorenstein, L. M.
Gundersen, A. H.
Gundersen, A. L.
Gundersen, G. A.
Gundersen, Gunnar
Gundersen, S. B., Jr.
Gundersen, T. E.
Harman, J. C.
Hayden, J. W.
Helliesen, P. J.
Hickey, A. W.
Higgins, C. K.
Himmelsbach, W. A.
Hullick, P. V.
Jensen, Alfhild
Jones, W. J.
Joseph, L. G.
Kalfayan, Bernard
Leiby, R. W., Jr.
MacEwen, A. R.
Mansheim, B. J.
McCann, John P.
McGarty, M. A.
McMahon, R. E.
McNamara, T. B.
Mildelfort, C. F.
Murphy, G. B., Jr.
Murphy, J. T.
O'Brien, M. J.
O'Meara, M. T.
Pauly, James P.
Perry, E. L.
Phillips, P. W.
Pribek, R. A.
Ramlow, R. W.
Rasmus, R. B.
Richter, J. R.
Satory, J. J.
Scheurich, Mary B.
Schmidt, C. F.
Schmidt, L. R.
Schneeberger, E. J.
Schuldes, R. E.
Sevenants, J. J.
Simones, J. J.
Simonson, S. W.
Sivertson, S. E.
Skemp, F. C.
Skemp, G. E.
Skemp, J. J.
Skemp, J. T.
Slungaard, Rolv
Thompkins, D. G.
Uhrich, G. I.
Watunya, M. J.
Wolf, F. H.
Whiteway, R. E.

Ladysmith:
Bauer, W. B. A. J.
Bennett, R. P.
Murphy, J. E.
Pagel, H. F.

Lake Geneva:
Beattie, J. W.
Bischof, H. F.
Hindall, B. C.
Hudson, E. D.
Jeffers, D. H., Jr.
Rauch, A. M.

Lake Mills:
Eck, G. E.
Liebenow, R. R.
Netzow, E. J.
Peterson, M. G.

Lancaster:
Bauman, K. L.
Becher, L. E.
Carey, H. W.
Hillery, G. C.
Houghton, E. M.

Laona:
Castaldo, E. F.
Ovitz, E. G.

Lena:
Rose, J. F.

Little Chute:
Buchanan, K. E.
Van Lieshout, F. X.

Lodi:
Groves, R. J.
Irwin, W. G.

Loyal:
Hable, A. P.

Luxemburg:
Majeski, H. E.
Rahr, H. C.

Madison:
Aageson, C. W.
Ainslie, R. B.
Albright, E. C.
Allen, J. C.
Allen, J. R.
Allin, R. N.
Anderson, A. D.
Anderson, Jeanne
Anderson, R. B.
Angevine, D. M.
Ansfield, F. J
Ashman, H. C.
Avari, P. S.
Barks, M. F.
Bamforth, Betty J.
Barbour, J. H.
Barreto, R. S. A.
Bartlett, W. H.
Bauman, B. J.
Becker, R. M.
Beilman, R. L.
Belknap, E. L., Jr.
Benish, G. A.
Bennett, Maxine
Bentley, J. E.
Berg, Mary C.
Berger, J. V., Jr.
Bernard, F. D.
Bessire, M. C.
Blair, A. J.
Bloodworth, J. M. B., Jr.
Blum, F. G., Jr.
Bogle, W. C.
Bohlman, D. C.
Boldon, E. I., Jr.
Borenz, H. F.
Botham, R. J.
Brandabur, J. J.
Brew, Barbara A.
Brindley, B. I.
Britton, D. M.
Brodhead, Wm. T.
Brown, Henry
Brown, J. G.
Bruno, D. S.
Bujard, R. S., Jr.
Burke, C. F.
Burke, Mead
Burke, Myra E.
Burnett, G. H.
Burns, E. M.
Burns, R. E.
Buxbaum, R. C.
Calvert, Charlotte
Campbell, R. E.
Cant, W. F.
Carter, H. M.
Chase, S. L.
Clatanoff, D. V.
Clausen, N. M.
Collins, J. D.
Collins, R. F.
Connors, D. M.
Cooksey, R. T.
Cookson, D. U.
Cooper, G. A.
Coryell, J. L.
Cowle, A. E.
Crennell, E. H.
Crocker, L. G.
Crowley, W. P., Jr.
Crummy, A. B., Jr.
Crumpton, C. W.
Curreri, A. R.
Curtis, J. K.
Davenport, Gordon, Jr.
Davidson, P. L.
Davis, F. A.
Davis, F. J.
Davis, M. D.
Dean, D. L.
Dean, F. K.
Dean, J. L.
Dean, J. P.
Demergian, Vaughn
Derus, Gerald J.
Dickie, Helen A.
Dieter, D. G.
Dimond, W. B.
Doehlert, C. A., Jr.
Dollard, J. E.
Domine, A. Z.
Doolittle, J. W.
Dudiak, Stephen
Duehr, P. A.
Dunn, W. S.
Eichman, P. L.
Ellis, J. C., Jr.
Erickson, M. T.
Erickson, T. C.
Evans, A. S.
Everett, H. C.
Ewell, G. H.
Farrell, R. X.
Fauerbach, Louis
Fellner, C. H.
Fliegel, M. B.
Forster, F. M.
Foseid, Oscar F.
Fosmark, C. A.
Foster, M. A.
Foster, Ruth C.
Frank, Jordan
Gale, J. W.
Gallo, G. L.
Ganser, L. J.
Garnett, G. M.
Gearhart, R. S.
Geppert, T. V.
Giles, L. T.
Glover, B. H.
Golden, F. F.
Golden, P. B.
Gordon, E. S.
Gottlieb, A. M.
Graham, D. T.
Grahek, A. S.
Greeley, H. P.
Grumke, E. H.
Guilford, H. M.
Hamel, Merle O.
Handa, Yoshio
Hank, G. C.
Harper, C. S.
Harper, S. B.
Harris, R. C.
Hartridge, T. L.
Hawk, E. A.
Healy, J. R.
Healy, W. G.
Hennen, R. J.
Hibma, O. V.
Hill, N. A.
Hinke, D. H.
Hobbins, W. B.
Hoff, A. D.
Hoffman, P. A.
Hogan, L. H.
Holmgren, L. E.
Hopkins, C. E.
Horswill, C. W.
Hummer, F. L.
Hunter, Amy Louise
Hurst, D. W.
Hutson, C. F.
Iams, A. M.
Inhorn, S. L.
Jackson, A. S.
Jackson, C. R.
Jackson, R. H., Jr.
Jaeschke, W. H.
Janicek, D. R.
Javid, Manucher
Joachim, F. G.
Johnson, E. E.
Johnson, J. R.
Johnson, R. O.
Johnson, S. A. M.
Jorris, E. H.
Juhl, J. H.
Juster, E. M.
Kabler, J. D.
Kanner, A. V.
Karzel, R. P.
Kaskey, E. T.
Kay, H. M.
Keepman, Jay P.
Kemp, T. S.
Kerrihard, G. N
Kiekhofer, William
Kilpatrick, Leslie G.
Kincaid, C. K.
Kline, Joyce C.
Klumper, Wilhelm
Knight, C. C.
Koenecke, F. H., Jr.
Koepke, D. E.
Kolner, E. H.
Koppa, J. F.
Kring, G. G.
Kroncke, G. M.
Kundert, P. R.
Kurtz, Esther C.
Lacke, C. L.
Land, J. F.
Lang, G. E.
Lang, J. L.
Lange, R. D.
Larson, F. C.
Lemmer, K. E.
Leonard, T. A., Jr.
Lewis, W. C.
Liebl, E. R.
Lindsay, W. T.
Lipp, Evelyn D.
Liske, E. A.
Longley, B. J.
Loveland, Pearl M.
Lubing, H. N.
Ludden, R. H.
Luetke, W. V.
Lyons, W. H.
Mahaffey, H. W.
Malec, J. P.

Maloof, G. J.
Marlow, Gordon V.
Marsden, W. H.
McAleavy, J. C.
McClung, John L.
McDermott, John P.
McDonough, K. B.
McIllece, Patricia E.
McIntosh, J. F.
Meisekothen, W. E.
Mendenhall, J. T.
Meyer, O. O.
Miezio, S.
Miller, J. E.
Miller, M. H.
Miller, S. M.
Mohs, F. E.
Monson, S. D.
Moore, J. N.
Morledge, John
Morrissey, J. F.
Mortensen, O. A.
Mueller, John J.
Mussey, W. C.
Neal, M. P., Jr.
Neaves, Noe
Nerein, T. J.
Nesbit, M. E.
Neupert, C. N.
Newman, J. R
Nicolaus, W. H.
Nordby, E. J.
Oakley, Dorothy W.
O'Connor, Robert E.
Okagaki, H. I.
Olson, R. W.
Oosterhous, G. E.
Orth, O. S.
Ottensmeyer, D. J.
Owen, R. H.
Parks, H. K.
Parsons, W. B., Jr.
Paul, L. W.
Peckham, B. M.
Peters, H. A.
Peterson, D. A.
Piper, P. G.
Pitts, F. R., Jr.
Podruch, P. E.
Pohle, E. A.
Preizler, Josef
Price, D. O.
Price, D. W.
Prouty, L. R.
Prouty, Margaret
Ptacek, L. J.
Puestow, K. L.
Puletti, F.
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Quisling, Sverre
Rahm, J. P., Jr.
Rankin, John
Reeck, L. K.
Reed, C. E.
Reese, H. H.
Reznichek, C. G.
Richtsmeier, A. J.
Ris, Hania W.
Roberts, L. M.
Rock, William
Roemer, E. P.
Rogers, S. C.
Roisum, B. H.
Rosenbloom, A. L.
Rotter, Royal
Rounds, W. M.
Rowe, G. G.
Rusch, K. H.
Ryder, E. K., Jr.
Sabin, Richard P.
Sachtjen, K. M.
Salick, J. A.
Samp, R. J.
Sarto, G. E.
Schafer, Etheldred L.
Schilling, R. F.
Schmidt, C. S.
Schmitz, R. D.
Schneiders, E. F.
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Schroeder, J. M.
Schubert, C. K.
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Schuster, D. S.
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Clasen, W. E.
Claudon, D. B.
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Coffey, W. L.,
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Cohen, A. M.
Cohen, D. J.
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Collopy, P. J.
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Conley, J. E.
Connaughton, J. P.
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Conway, J. P.
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Cornfield, J. R.
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Flynn, R. T.
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Foley, T. J.
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Fritz, R. J.
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Goodman, J. S.
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Hotter, J. T.
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Madison, F. W.
Majewski, J. T.
Mallin, S. R.
Malloy, D. J.
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Malnekoff, B. J.
Mann, D. H.
Mann, R. W.
Maranan, I. L.
Margoles, F. C.
Marino, Rita
Mark, L. K.
Marks, J. L.
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Markson, J. W.
Markson, L. S.
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Mason, E. W.
Mattingly, R. F.
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Maxwell, H. P.
Maxwell, J. W.
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McCabe, John
McCabe, R. W.
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McClellan, W. A.
McCormick, T. F.
McCormick, Thomas F.
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McDonald, C. F.
McDonald, R. E.
McDuffie, J. J.
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McKenna, J. L.
McKenty, J. D.
McKittrick, N. W.
McLaughlin, B. C.
McMahon, F. B.
McMahon, H. O.
McMahon, J. P.
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Means, J. A., III
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Mendeloff, Elton
Mendeloff, Hyman
Mensing, E. H.
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Meves, T. F.
Meyer, J. M.
Meyers, Alfred
Mikolajczak, N. A.
Millen, F. J.
Miller, D. D.
Miller, E. W.
Miller, H. L.
Miller, L. E.
Miller, O. E.
Mills, W. R.
Miner, H. B.
Mitcham, LeRoy
Mitz, Morris
Moel, Morris
Mohanty, R. K.
Molsberry, J. M.
Montgomery, R. P.
Mookerjee, M. K.
Moore, G. E.
Morgan, J. E.
Morgan, R. L.
Morgan, S. F.
Morrison, R. C.
Morter, H. V.
Morter, R. E.
Morton, S. A.
Mossey, R. O.
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Mroczkowski, C. J.
Mueller, G. F.
Mueller, J. J.
Mueller, Nina T.
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Murphy, J. A.
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Natenshon, A. L.
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Nellen, J. R.
Niland, P. J.
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Nimz, R. A.
Noonan, P. J.
Northey, T. M.
Nothum, J. P.
Oberbreckling, P. E.
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O'Connor, T. M.
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Olinger, J. K.
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Olson, C. R.
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Onderak, E. P.
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Ovitt, D. W.
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Owen, J. D.
Owens, A. J.
Oxman, E. M.
Paine, E. M.
Palabrica, A. R.
Palermo, Geo. B.
Palese, J. A.
Pallasch, F. J.
Paquette, L. J.
Park, W. C.
Paulbeck, T. M.
Paulissen, J. P.
Pawlowski, J. M.
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Perlson, S. G.
Perssion, Leo B.
Pessin, S. B.
Peterman, M. G.
Peters, B. J.
Peterson, E. F.
Peterson, J. C.
Pfeffer, T. J.
Pfeifer, W. M.
Phillips, M. F.
Phillips, W. S.
Piaskoski, R. G.
Pick, J. W.
Pierson, P. S.
Pisciotta, A. V.
Pittelkow, R. B.
Pleyte, A. A.
Pohle, H. W.
Poindexter, G. W.
Polacek, M. A.
Polacheck, W. S.
Pollack, S. K.
Pollard, R. E.
Popp, Albert
Presti, A. A.
Price, D. J.
Prier, T. A.
Prudowsky, H. H.
Puchner, Thomas
Pugh, G. J.
Pulito, F. J.
Puls, T. B.
Purtell, P. J.
Purtell, R. F.
Quick, A. J.
Quinn, G. A.
Raasch, H. M.
Rabin, Allen
Raitz, I. E.
Ramin, J. E.
Rand, A. A.
Rand, Harold
Rank, R. T.
Rastetter, J. W.
Ratke, Donald
Regan, J. M.
Regan, J. R.
Reifenrath, I. B.
Reifenrath, W. E.
Reik, R. P.
Reinke, C. C.
Rettig, E. H.
Rettig, Frank
Reuter, M. J.
Rhodes, J. D.
Rice, E. L.
Rice, R. L.
Rife, C. S.
Rikkers, D. F.
Rinder, R. S.
Ritchie, Gorton
Robbins, L. S.
Rodenbeck, A. F.
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Rogers, E. H.
Rolfs, T. H.
Roncke, G. J.
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Rose, W. R.
Rosenbaum, F. F.
Rosenberg, S. W.
Rosenberger, A. I.
Rosenheimer, L. M.
Rosenthal, Samuel
Ross, F. A.
Rothman, L. E.
Rotter, E. J.
Rouman, W. C.
Royce, Owen, Jr.

Ruch, D. M.
Ruehl, R. L.
Rueth, J. E.
Ruff, L. L.
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Ryan, P. W.
Ryan, T. E.
Sabljak, E. J.
Sackin, H. D.
Sadoff, H. B.
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Sakaguchi, Shimpei
Saketos, T. P.
Salinsky, L. V.
Saltzstein, E. C.
Sander, O. A.
Sanders, A. C., Jr.
Sanfelippo, A. J.
Santer, D. G.
Sargent, J. W.
Sass, L. C.
Sattler, M. E.
Sauter, K. E.
Savino, P. R.
Savitt, A. J.
Schacht, W. J.
Schaeffer, B. S.
Schalmo, E. H., Jr.
Schelble, E. J.
Schelble, J. A.
Schelble, J. P.
Schiedt, R. A.
Schlomovitz, B. H.
Schlomovitz, H. H.
Schmidt, A. C.
Schmidt, C. E.
Schmidt, D. K.
Schmidt, E. C.
Schmidt, H. G.
Schmidt, R. A.
Schmidt, R. E.
Schmit, Louis
Schmitz, J. T.
Schnapp, A. C.
Schneeberger, L. J.
Schneider, C. C.
Schneider, C. R.
Schoenkerman, B. B.
Scholter, E. A. W.
Schowalter, R. P.
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Schroeder, C. M.
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Schulz, Irwin
Schumacher, H. S.
Schutte, A. G.
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Schwartz, A. B.
Schwartz, S. F.
Schweiger, L. R.
Schweitzer, G. J.
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Seelman, J. J.
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Sennett, L. W.
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Shapiro, W. D.
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Silbar, S. J.
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Simonsen, T. E.
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Smith, M. B.
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Spitz, M. M.
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Sproule, R. T.
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Strassburger, R. H.
Straus, G. D.
Strawn, E. Y.
Studley, W. H.
Stula, G. D.
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Sullivan, J. T.
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Temple, R. L.
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Thatcher, D. S.
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Thomas, P. W.
Thomas, W. D.
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Thompson, R. D.
Thomson, N. R.
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Torcivia, S. S.
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Uszler, L. B.
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Walton, W. B.
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Weisfeldt, S. C.
Weller, R. R.
Wells, Marvin
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Wengelewski, H. B.
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Werner, D. J.
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Wild, J. P.
Wilets, J. B.
Wilets, J. C.
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Willson, D. M.
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Woloschek, W. J.
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Wolters, H. F.
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Worman, L. W.
Worsencraft, H. M.
Wright, H. H.
Wyman, J. F.
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Yatso, M. G.
Yellick, C. W.
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Young, W. N.
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Irvin, J. M.
Kindschi, L. G.
Kundert, F. W.
Miller, C. O.
Mings, D. E.
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Stormont, J. R.
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Zach, R. G.
Zupanc, E. A.

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Mount Horeb:
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Kelm, G. J.

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Brunckhorst, F. O.
Canavan, J. P.
Colgan, H. J.
Davis, T. B.
Douglas, R. F.
Graham, A. P.
Hardie, G. H.
Haselow, J. R.
Hathaway, W. R.
Kirchgeorg, Clemens
Pansch, F. N.
Petersen, G. W.
Quade, R. H.
Regan, D. M.
Ryan, D. J.
Schwab, R. L.
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Suechting, R. L.
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Yount, L. J.

New Franken:
Looze, J. A.

New Glarus:
Hicks, E. V.
Marty, P. H.

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Larme, F. P.

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Koch, C. B.
Weston, C. L.

New London:
Dernbach, G. P.
Monsted, J. W.
Pfeifer, F. J.
Schmallenberg, H. C.
Weber, J. W.

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Weller, L. J.

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Claude, J. L.
Driscoll, L. J.
Epperson, D. P.
Frank, E. B.
Goral, T. J.
James, W. D.
Janssen, W. C.
Matt, J. R.
Miller, G. D.
Mills, E. G.
Nammacher, T. H.
O'Hara, J. J.
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Schuele, D. T.
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Schumacher, J. P.
Stemper, Irene T.
Theobald, P. B.
Weir, E. F.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, P. M.

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Johnson, E. S.
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Danforth, Q. H.
Enrich, P. S.
Graber, L. D.
Graiewski, S. J.
Greenwood, Ben. S.
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Guenther, V. G.
Hahn, W. V.
Haines, M. C.
Hillenbrand, H. M.
Hughes, J. B.
Kivlin, T. M.
Koehler, A. G.
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Kuhn, R. V.
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Meli, J. V.
Monday, Harvey
Petersik, J. T.
Pfefferkorn, E. B.
Romberg, H. A.
Scheuermann, N. M.
Steele, G. A.
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Stone, L. H.
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Wagner, R. F.
Wagner, W. A.
Wheeler, W. P.
Williams, E. B.
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Peshtigo:
Barrette, Antoine
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Phillips:
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Rens, J. L.

Plain:
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Stuessy, M. F.

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Mueller, J. F.
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Taylor, S. F.
Taylor, W. A.
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Poynette:
Dryer, R. B.
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Bruton, J. T.
Buckley, W. E.
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Christenson, C. W.
Constantine, C. E.
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Covell, K. W.
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Docter, J. C.
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Henken, W. F.
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Vivian, R. S. ---Naples, Florida
Von Ruden, W. J. ---Burlingame, California
Wells, M. R. ---Belleville, Illinois
Werba, D. R. ---Phoenix, Arizona
Weston, E. L. ---Academy, Colorado
White, E. F. ---Harlingen, Texas
Winkler, H. A. ---Denver, Colorado
Zimmer, R. W., Jr. ---Spokane, Washington

Members Serving In The Armed Forces

Arkins, J. A. ---Milwaukee, Wisconsin
Bolton, R. L. ---Larson, Washington
Brown, R. C. ---APO 282, New York, New York
Bultema, J. H. ---Muskegon, Michigan
Chapman, M. J. ---Bethesda, Maryland
Chisholm, D. E. ---Kenosha, Wisconsin
Cornfield, A. L. ---Wichita Falls, Texas
Draelos, T. T. ---Dugway Proving Grounds, Utah
Enders, L. J. ---Otis AFB, Massachusetts
Fitzgerald, R. E. ---Fort Knox, Kentucky
Flaherty, T. T. ---Amarillo, Texas
Goldbeck, L. O. ---San Francisco, California
Goldberger, R. J. ---APO 23, New York, New York
Gordon, J. J. ---Johnsonville, Pennsylvania
Hanson, J. R. ---Oceanside, California
Howland, D. E. ---Phoenix, Arizona
Kinsey, J. L. ---Washington, D. C.
Kirchner, M. M. ---Fort Jackson, South Carolina
Kivlin, T. M. ---Oshkosh, Wisconsin
Korbitz, B. C. ---Randolph AFB, Texas
Kratchovil, C. H. ---APO 633, New York, New York
Kreissl, L. J. ---Santa Rosa, California
Lasser, A. E. ---Rantoul, Illinois
Locksmith, J. P. ---Clovis, New Mexico
Maloney, J. D. ---Valdosta, Georgia
Martens, T. J. ---Fort Ord, California
McCabe, L. B. ---P.O. 757, New York, New York
Melms, F. A., Jr. ---APO 320, New York, New York
Mohler, G.T. ---Tacoma, Washington
Murray, R. C. ---Indianapolis, Indiana
Pettera, R. L. ---Fort Lewis, Washington
Rammer, M. A., Jr. ---APO 28, New York, New York
Rapkin, M. A. ---Rantoul, Illinois
Reslock, C. P. ---Waupun, Wisconsin
Roberts, G. W. ---Shephard AFB, Texas
Rogers, C. E. ---St. Albans, New York
Roller, M. C. ---APO 25, San Francisco, California
Ruf, D. F. ---Darlington, Wisconsin
Schatz, W. R. ---Modesto, California
Schmidt, C. H. ---Omaha, Nebraska
Schmidt, R. D. ---Ellsworth AFB, South Dakota
Schulz, J. T. ---Coronado, California
Scrimenti, R. J. ---Guantanamo Bay, Cuba
Sheldon, E. O., Jr. ---Fort Carson, Colorado
Stack, E. G ---Fort Lewis, Washington
Taylor, C. A., Jr. ---Amarillo AFB, Texas
Valaske, M. J. ---San Diego, California
Van Susteren, J. A. ---Onalaska, Wisconsin
Werra, R. J. ---Modesto, California
Woods, S. M. ---March AFB, California

Honorary Members

Bradley, H. C. Ph.D. ---Berkeley, California
Clark, P. F., Ph.D. ---Madison, Wisconsin
Foerster, O. H. ---Milwaukee, Wisconsin
Hardman, H. F. ---Milwaukee, Wisconsin
Hunter, A. L. ---Madison, Wisconsin
McCracken, R. W. ---Union Grove, Wisconsin
McMahon, H. O. ---Milwaukee, Wisconsin
Meek, W. J., Ph.D. ---Ft. Myers Beach, Florida
Miller, E. W. ---Milwaukee, Wisconsin
Mortensen, O. A. ---Madison, Wisconsin
Pusey, W. A., Ph.D. ---Chicago, Illinois
Shideman, F. E. ---Madison, Wisconsin
Sisk, I. R. ---Madison, Wisconsin
Sullivan, W. E., Ph.D. ---Claremont, California

Foreign Members

Bowers, J. Z. ---------- Kyoto, Japan
Grant, L. C. ---------- Nigeria, West Africa
Homsi, M. R. K. ---------- Syria, U.A.R.
Olsen, V. B. ---------- Chittagong, East Pakistan
Schlaepfer, K. ---------- Cuernavaca, Morelos, Mexico

Life Members

Allen, W. J. ---------- Beloit
Baker, G. R. ---------- Tomahawk
Bauer, K. T. ---------- West Bend
Bayer, W. H. ---------- Merrill
Beck, A. A. ---------- Wautoma
Beebe, S. D. ---------- Sparta
Bodden, A. M. ---------- Milwaukee
Bornstein, Max ---------- Milwaukee
Brehm, H. J. ---------- Racine
Brunckhorst, F. O. ---------- Neenah
Cairns, R. U. ---------- River Falls
Campbell, W. B. ---------- Waukesha
Christensen, F. C. ---------- Racine
Clark, W. T. ---------- Janesville
Connell, F. G. ---------- Oshkosh
Crockett, W. W. ---------- Beloit
Eck, G. E. ---------- Lake Mills
Epley, O. H. ---------- New Richmond
Fazen, L. E. ---------- Racine
Fechter, F. J. ---------- Milwaukee
Forkin, G. E. ---------- Menasha
Gramling, J. J. ---------- Milwaukee
Hammond, F. W. ---------- Manitowoc
Heeb, H. J. ---------- Howley in the Hills, Florida
Herner, Wm. L. ---------- Milwaukee
Herrington, R. E. ---------- Milwaukee
Holbrook, A. T. ---------- Milwaukee
*Hogan, John H. ---------- Racine
Kay, H. M. ---------- Madison
Kleinboehl, J. W. ---------- Mercer
Knauf, N. J. ---------- Chilton
Knutson, Oscar ---------- Osseo
Kradwell, W. T. ---------- Wauwatota
Leonard, C. W. ---------- Fond du Lac
*Levitas, I. E. ---------- Green Bay
Lockhart, C. W. ---------- Mellen
Ludden, H. D. ---------- Mineral Point
Lumsden, William ---------- Menomonie
Marshall, V. F. ---------- Appleton
Meusel, H. H. ---------- Fond du Lac
Moore, L. A. ---------- Monroe
Nauth, D. F. ---------- Kiel
Pope, F. W. ---------- Racine
Potter, R. P. ---------- Marshfield
Raymond, R. G. ---------- Brownsville
Rolfs, T. H. ---------- Milwaukee
Schmit, Louis ---------- Milwaukee
Smith, S. M. B. ---------- Wausau
Spitz, M. M. ---------- Milwaukee
Stebbins, W. W. ---------- St. Petersburg, Florida
Steele, G. A. ---------- Oshkosh
Stemper, Irene T. ---------- Oconomowoc
Tasche, C. T. ---------- Sheboygan
Thomas, W. O. ---------- Clinton
Towne, W. H. ---------- Hortonville
Twohig, D. J. ---------- Fond du Lac
Van Kirk, F. W. ---------- San Francisco, California
Washburn, R. G. ---------- Milwaukee
Weber, A. J. ---------- Milwaukee
Wetzler, S. H. ---------- Milwaukee
Wheeler, W. P. ---------- Oshkosh
Ziegler, John E. B. ---------- Eau Claire

* Granted life membership in 1962.

Prenatal Facts

SUGGESTED PROCEDURE } **File at hospital in last month of pregnancy. If there are indications of possible premature delivery file earlier. Direct this form to the supervisor of obstetrics of the hospital to which the patient will be admitted.**

Name ---------- **Address** ---------- **igion** ----------
Expected date of confinement ---------- -- **Para** --------
Number of abortions ---------- **miscarriag** ---------- **del.** ----------
multiple birt
Natu

Weig
Speci
Chest
Evaluati
Wasserma
Coombs te
Date of visi
Weight
Heart

FOR YOUR CONVENIENCE, DOCTOR . . .

The Division on Maternal and Child Welfare has prepared a sheet which is recommended for use by all Wisconsin physicians in reference to hospital care of obstetrical patients . . .

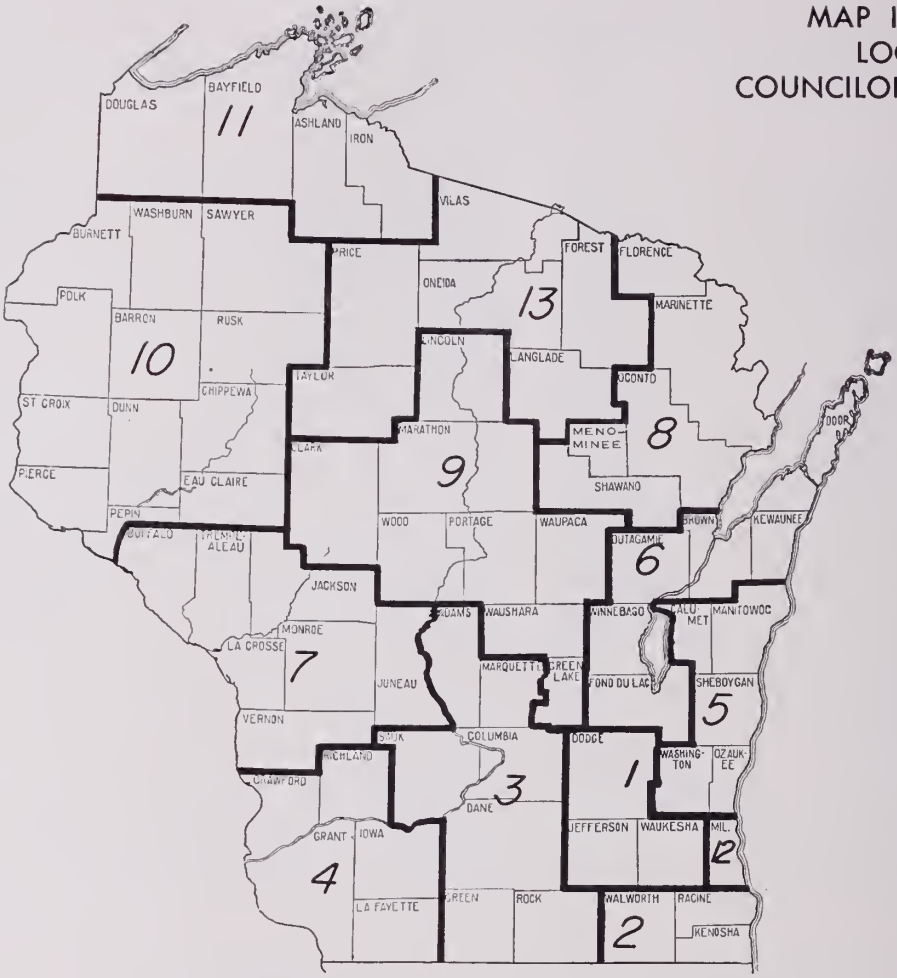
You will find this of convenience to you, and of much value to your obstetrical patients. It will alert the hospital to proper care when your patient is admitted for delivery.

Per pad of 100 forms—$2.00.

Write:
DIVISION ON MATERNAL AND CHILD WELFARE
State Medical Society of Wisconsin
Box 1109, Madison 1, Wisconsin

STATE MEDICAL SOCIETY OF WISCONSIN
MEDICINA NUSQUAM NON EST

MAP INDICATING LOCATION OF COUNCILOR DISTRICTS



COUNCILORS:

FIRST DISTRICT:
W. D. James, M.D., Oconomowoc

SECOND DISTRICT:
G. J. Schulz, M.D., Union Grove

THIRD DISTRICT:
E. J. Nordby, M.D., Madison
J. H. Houghton, M.D., Wisconsin Dells
M. D. Davis, M.D., Milton

FOURTH DISTRICT:
E. M. Dessloch, M.D., Prairie du Chien

FIFTH DISTRICT:
P. B. Blanchard, M.D., Cedarburg

SIXTH DISTRICT:
H. J. Kief, M.D., Fond du Lac
George Nadeau, M.D., Green Bay

SEVENTH DISTRICT:
J. C. Fox, M.D., La Crosse

EIGHTH DISTRICT:
J. M. Bell, M.D., Marinette

NINTH DISTRICT:
R. W. Mason, M.D., Marshfield

TENTH DISTRICT:
R. C. Frank, M.D., Eau Claire

ELEVENTH DISTRICT:
V. E. Ekblad, M.D., Superior

TWELFTH DISTRICT:
L. J. Van Hecke, M.D., Milwaukee
W. J. Houghton, M.D., Milwaukee
D. M. Willson, M.D., Milwaukee
S. L. Chojnacki, M.D., Milwaukee
S. W. Hollenbeck, M.D., Milwaukee

THIRTEENTH DISTRICT:
W. P. Curran, M.D., Antigo

Officers and Councilors 1962-1963

State Medical Society of Wisconsin

OFFICERS OF THE SOCIETY

PRESIDENT_____Nels A. Hill, M.D., Madison
304 West Washington Avenue

PRESIDENT-ELECT____W. J. Egan, M.D., Milwaukee
720 North Jefferson Street

SECRETARY_____Mr. C. H. Crownhart, Madison
330 East Lakeside Street

ASSISTANT SECRETARIES_Mr. Roy T. Ragatz, Madison
Mr. Earl R. Thayer, Madison
330 East Lakeside Street

TREASURER_____F. L. Weston, M.D., Madison
1 South Pinckney Street

SPEAKER_____Robert E. Callan, M.D., Milwaukee
1733 West Wisconsin Avenue

VICE-SPEAKER_____H. W. Carey, M.D., Lancaster
257 Madison Street

COUNCILORS

(J. C. Fox, M.D., La Crosse, Chairman)
(J. M. BELL, M.D., Marinette, Vice-chairman)

DISTRICTS*

FIRST: Dodge, Jefferson and Waukesha County Societies. W. D. James, M.D., 340 Summit Avenue, Oconomowoc, 1963.

SECOND: Kenosha, Racine and Walworth County Societies. G. J. Schulz, M.D., 722 16th Avenue, Union Grove, 1963.

THIRD: Dane, Columbia–Marquette–Adams, Green, Rock and Sauk County Societies. E. J. Nordby, M.D., 2715 Marshall Court, Madison, 1964; J. H. Houghton, M.D., Wisconsin Dells, 1963; M.D. Davis, M.D., 309 College Street, Milton, 1965.

FOURTH: Crawford, Grant, Iowa, Lafayette and Richland County Societies. E. M. Dessloch, M.D., Medical Park, Prairie du Chien, 1964.

FIFTH: Calumet, Manitowoc, Sheboygan, Washington and Ozaukee County Societies. P. B. Blanchard, M.D., 204 North Washington Avenue, Cedarburg, 1964.

SIXTH: Brown, Door–Kewaunee, Fond du Lac, Outagamie and Winnebago County Societies. H. J. Kief, M.D., 104 South Main Street, Fond du Lac, 1964; George Nadeau, M.D., 128 East Walnut Street, Green Bay, 1965.

SEVENTH: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. J. C. Fox, M.D. (Chairman), 212 South Eleventh Street, La Crosse, 1965.

EIGHTH: Marinette–Florence, Oconto, and Shawano County Societies. J. M. Bell, M.D. (Vice-chairman), 516 Houston Street, Marinette, 1965.

NINTH: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. R. W. Mason, M.D., 650 South Central Avenue, Marshfield, 1965.

TENTH: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk and Rusk County Societies. R. C. Frank, M.D., 550 North Dewey Street, Eau Claire, 1965.

ELEVENTH: Ashland–Bayfield–Iron and Douglas County Societies. V. E. Ekblad, M.D., 1507 Tower Avenue, Superior, 1963.

TWELFTH: The Medical Society of Milwaukee County. L. J. Van Hecke, M.D., 161 West Wisconsin Avenue, Milwaukee, 1963; W. J. Houghton, M.D., 2943 North Oakland Avenue, Milwaukee, 1963; D. M. Willson, M.D., 2618 East Shorewood Blvd., Milwaukee, 1964; S. L. Chojnacki, M.D., 3122 South Thirteenth Street, Milwaukee 15, 1965; S. W. Hollenbeck, M.D., 2650 West Fond du Lac Avenue, Milwaukee 6, 1965.

THIRTEENTH: Forest, Langlade, Oneida–Vilas and Price–Taylor County Societies. W. P. Curran, M.D., 700½ Fifth Avenue, Antigo, 1962.

PAST PRESIDENT_____L. H. Lokvam, Kenosha
753 Fifty-eighth Street

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

A. A. Quisling, M.D. (1963)_____Madison
2 West Gorham Street

R. E. Galasinski, M.D. (1963)_____Milwaukee
3333 South 27th Street

L. O. Simenstad, M.D. (1964)_____Osceola
141 North Cascade

E. L. Bernhart, M.D. (1964)_____Milwaukee
2714 West Burleigh Street

Alternates

W. B. Hildebrand, M.D. (1963)_____Menasha
59 Racine Street

George Collentine, Jr., M.D. (1963)_____Milwaukee
2266 North Prospect Avenue

John M. Bell, M.D. (1964)_____Marinette
516 Houston Street

C. J. Picard, M.D. (1964)_____Superior
425 Twenty-first Avenue East

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* Map indicating location of councilor districts, page 80.

Note: Officers, councilors, delegates, and members of Standing Committees are elected at the Annual Meeting in May.

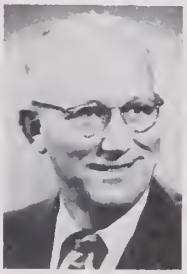
Standing Committees—1962-1963

State Medical Society of Wisconsin

COMMITTEE ON CANCER

Paul M. Cunningham, M. D.
Chairman

Paul M. Cunningham, M.D. (1963) _____Appleton
Chairman 401 North Oneida Street
Robert S. Monk, M.D. (1963)_____Waukesha
149 Wisconsin Avenue
J. R. Hoon, M.D. (1963) _____Sheboygan
1011 North 8th Street
R. R. Mataczynski, M.D. (1963) _____Superior
1514 Ogden Avenue
J. W. Boren, Jr., M.D. (1964)_____Marinette
1510 Main Street
M. W. Stuessy, M.D. (1964)_____Brodhead
605 East Fourth Avenue
G. H. Williams, M.D. (1964)_____Marshfield
Marshfield Clinic
Ralph C. Frank, M.D. (1965)_____Eau Claire
550 North Dewey Street
G. I. Uhrich, M.D. (1965)_____La Crosse
212 South Eleventh Street
R. C. Glise, M.D. (1965)_____Richland Center
118 West Mill Street
G. A. Smiley, M.D. (1965)_____Delavan
107 North Third Street
J. J. Gramling, Jr., M.D. (1965)_____Milwaukee
324 East Wisconsin Avenue
J. F. Brown, M.D. (1965)_____Rhinelander
1020 Kabel Avenue



COMMITTEE ON GRIEVANCES

E. D. Sorenson, M.D.
Chairman

E. D. Sorenson, M.D. (1965)_____Elkhorn
Chairman 104 South Wisconsin Street
R. E. Fitzgerald, M.D. (1963) _____Milwaukee
2218 North Third Street
K. A. Morris, M.D. (1963) _____Merrill
705 East First Street
J. D. Leahy, M.D. (1963) _____Park Falls
170 Fourth Avenue North
H. J. Belson, M.D. (1964)_____Manitowoc
904A South Eighth Street
R. R. Richards, M.D. (1964)_____Eau Claire
605 Walker Avenue
T. J. Nereim, M.D. (1964)_____Madison
333 Glen Way
E. W. Mason, M.D. (1965)_____Milwaukee
324 East Wisconsin Avenue
R. W. Mason, M.D. (1965)_____Marshfield
650 South Central Avenue

COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS

D. E. Dorchester, M.D.
Chairman

D. E. Dorchester, M.D. (1963)_____Sturgeon Bay
Chairman 10 North Third Avenue
J. E. Martin, Jr., M.D. (1963) _____Delavan
607 Walworth Avenue
R. J. Botham, M.D. (1963)_____Madison
1313 Fish Hatchery Road
J. S. Devitt, M.D. (1964)_____Milwaukee
944 North Jackson Street
Louis Olsman, M.D. (1964)_____Kenosha
625 57th Street
C. A. Olson, M.D. (1964)_____Baldwin
C. J. Picard, M.D. (1965)_____Superior
425–21st Avenue, East
D. G. MacMillan, M.D. (1965)_____Barron
1220 Woodland
W. E. Acheson, M.D. (1965)_____Valders
Liberty Street

COMMISSION ON PUBLIC POLICY

R. G. Zach, M.D.
Chairman

Robert G. Zach, M.D. (1967) ---------- Monroe
Chairman 810–19th Avenue

W. T. Russell, M.D. (1966) ---------- Sun Prairie
Vice-chairman 215 East Main Street

H. E. Oppert, M.D. (1967) ---------- Viroqua
318 South Main Street

Earl C. Quackenbush, M.D. (1967) ---------- Hartford
14 North Main Street

D. N. Goldstein, M.D. (1963) ---------- Kenosha
723–58th Street

Norbert Enzer, M.D. (1964) ---------- Milwaukee
948 North Twelfth Street

L. J. Kurten, M.D. (1965) ---------- Racine
810 Main Street

President, ex officio
President-elect, ex officio
Secretary, ex officio

COMMISSION ON SCIENTIFIC MEDICINE

R. W. Farnsworth, M. D.
Chairman

R. W. Farnsworth, M.D. (1963) ---------- Janesville
Chairman 305 Court Street

J. K. Curtis, M.D. (1967) ---------- Madison
2500 Overlook Terrace

A. R. Curreri, M.D. (1964) ---------- Madison
1300 University Avenue

P. T. Bland, M.D. (1965) ---------- Westby
107 North Main Street

G. E. Collentine, Jr., M.D. (1966) ---------- Milwaukee
2266 North Prospect Avenue

Victor S. Falk, Jr., M.D. ---------- Edgerton
5 W. Rollin Street

John S. Hirschboeck, M.D. ---------- Milwaukee
561 North Fifteenth Street

* * *

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

Chairman of the Council, Chairman
Immediate Past President
President
President-elect
Secretary

COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION

R. S. Gearhart, M. D.
Chairman

R. S. Gearhart, M.D. (1965) ---------- Madison
Chairman 621 South Park Street

C. J. Picard, M.D. (1964) ---------- Superior
425–21st Avenue, East

G. B. Murphy, Jr., M.D. (1964) ---------- La Crosse
1836 South Avenue

Edgar End, M.D. (1964) ---------- Wauwatosa
7608 West State Street

T. H. McDonell, M.D. (1965) ---------- Waukesha
217 Wisconsin Avenue

S. L. Henke, M.D. (1963) ---------- Eau Claire
314 Grand Avenue

T. E. Boston, M.D. (1963) ---------- Hillsboro
840 Water Avenue

H. G. Bayley, M.D. (1963) ---------- Beaver Dam
116 Iroquois Parkway

M. V. Overman, M.D. (1965) ---------- Neillsville
Neillsville Clinic

John S. Hirschboeck, M.D., Dean, Marquette University School of Medicine ---------- Milwaukee
Ex officio 561 North Fifteenth Street

* * *

COUNCIL COMMITTEES

Appointments to the following committees are made by the chairman of the Council at the time of the Annual Meeting in May.

Committees of the Council (composed of members of Council):

- Economic Medicine
- Executive
- Finance
- Planning
- Scientific Medicine

Council Committees:

- Clinical Medicine
- Disaster Medical Care
- Commission on Medical Care Plans
- Commission on State Departments
- Editorial Board
- Military Medical Service
- Health Economics of American Life (HEAL)

COMPONENT COUNCIL COMMITTEES 1962–1963

(Appointed by the Chairman of the Council and composed of members of the Council)

EXECUTIVE COMMITTEE

James C. Fox, M.D._____La Crosse
Chairman of the Council
212 South 11th Street

J. M. Bell, M.D._____Marinette
Chairman, Scientific Medicine
516 Houston Street

Ralph C. Frank, M.D._____Eau Claire
Chairman, Planning
550 North Dewey Street

E. M. Dessloch, M.D.__Prairie du Chien
Chairman, Finance
Medical Park

J. H. Houghton, M.D.__Wisconsin Dells
Chairman, Economic Medicine
Box 325

Ex officio: N. A. Hill, M.D., president
_____Madison
Chairman
304 West Washington Avenue

W. J. Egan, M.D., president-elect
_____Milwaukee
720 North Jefferson Street

L. H. Lokvam, M.D., past president
_____Kenosha
723 58th Street

SCIENTIFIC MEDICINE

J. M. Bell, M.D._____Marinette
Chairman
516 Houston Street

H. J. Kief, M.D._____Fond du Lac
104 South Main Street

W. P. Curran, M.D._____Antigo
700 Fifth Avenue

W. J. Houghton, M.D._____Milwaukee
2943 North Oakland Avenue

S. W. Hollenbeck, M.D.____Milwaukee
2650 West Fond du Lac Avenue

ECONOMIC MEDICINE

J. H. Houghton, M.D.__Wisconsin Dells
Chairman
Box 325

P. B. Blanchard, M.D.____Cedarburg
204 North Washington Avenue

G. J. Schulz, M.D._____Union Grove
722 15th Avenue

D. M. Willson, M.D._____Milwaukee
2618 East Shorewood Boulevard

George Nadeau, M.D._____Green Bay
128 East Walnut Street

PLANNING

Ralph C. Frank, M.D._____Eau Claire
Chairman
550 North Dewey Street

V. E. Ekblad, M.D._____Superior
1507 Tower Avenue

R. W. Mason, M.D._____Marshfield
Marshfield Clinic

L. J. Van Hecke, M.D.____Milwaukee
6001 West Center Street

Milton D. Davis_____Milton
309 College Street

FINANCE

E. M. Dessloch, M.D._Prairie du Chien
Chairman
Medical Park

E. J. Nordby, M.D._____Madison
2715 Marshall Court

W. D. James, M.D._____Oconomowoc
340 Summit Avenue

Ralph C. Frank, M.D.____Eau Claire
550 North Dewey Street

J. M. Bell, M.D._____Marinette
516 Houston Street

S. L. Chojnacki, M.D._____Milwaukee
3122 South 13th Street

Ex officio: F. L. Weston, M.D.,
Treasurer_____Madison
One South Pinckney Street

Note: Chairman Fox is an ex-officio member of the last four committees.

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

SECTION ON DERMATOLOGY

President _____ Roger Laubenheimer, Milwaukee
Secretary _____ Robert Pittelkow, Milwaukee
Delegate _____ Joel Taxman, Milwaukee
Alternate _____ James Bringe, Sheboygan

SECTION ON GENERAL PRACTICE

President _____ J. S. Devitt, Milwaukee
Secretary _____ J. A. Kelble, Milwaukee
Delegate _____ R. R. Richards, Eau Claire
Alternate _____ J. A. Kelble, Milwaukee

SECTION ON INTERNAL MEDICINE

Chairman _____ W. K. Simmons, Rhinelander
Secretary _____ G. E. Gutmann, Janesville
Delegate _____ L. J. Kurten, Racine
Alternate _____ R. L. Gilbert, La Crosse

SECTION ON NEUROLOGY AND PSYCHIATRY

President _____ Charles W. Landis, Milwaukee
Secretary _____ C. W. Osgood, Wauwatosa
Delegate _____ K. M. Keane, Appleton
Alternate _____ R. E. O'Connor, Madison

SECTION ON OBSTETRICS AND GYNECOLOGY

President _____ B. M. Peckham, Madison
Secretary _____ R. E. Whitsitt, Madison
Delegate _____ D. O. Price, Madison

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Chairman _____ W. C. Randolph, Manitowoc
Secretary _____ Clemens Kirchgeorg, Neenah
Delegate _____ R. T. Schmidt, Green Bay
Alternate _____ Frank Treskow, Milwaukee

SECTION ON ORTHOPEDICS

President _____ Paul J. Collopy, Milwaukee
Secretary _____ Louis Kagen, Milwaukee
Delegate _____ John O'D. McCabe, Milwaukee
Alternate _____ John Van Driest, Sheboygan

SECTION ON PATHOLOGY

President _____ D. J. Carlson, Milwaukee
Secretary _____ D. J. La Fond, Milwaukee
Delegate _____ J. L. Teresi, Milwaukee
Alternate _____ Lars Kleppe, Beloit

SECTION ON PEDIATRICS

Chairman _____ S. L. Griggs, Green Bay
Delegate _____ L. M. Simonson, Sheboygan
Alternate _____ K. J. Winters, Wauwatosa

SECTION ON PUBLIC HEALTH

President _____ J. A. Van Susteren, Onalaska
Secretary _____ G. M. Shinners, Green Bay
Delegate _____ G. M. Shinners, Green Bay
Alternate _____ Elmer E. Bertolaet, West Allis

SECTION ON RADIOLOGY

Chairman _____ B. W. Byrne, Milwaukee
Secretary _____ C. E. Schmidt, Milwaukee
Delegate _____ Howard Mauthe, Fond du Lac
Alternate _____ Leslie Jones, Racine

SECTION ON SURGERY

Chairman _____ A. R. Curreri, Madison
Secretary _____ Norman O. Becker, Fond du Lac
Delegate _____ John T. Mendenhall, Madison
Alternate _____ Roy B. Larsen, Wausau

SECTION ON UROLOGY

President _____ John P. McCann, La Crosse
Secretary _____ J. T. Hotter, Milwaukee
Delegate _____ F. M. Hilpert, Racine
Alternate _____ Arthur Jacobsen, Racine

SMS COUNCIL COMMITTEES 1962–1963

(Appointed by the Chairman of the Council and composed of members of the State Medical Society)

DISASTER MEDICAL CARE

J. S. Wier, M.D._____Fond du Lac
Chairman
80 Sheboygan Street
E. A. Bachhuber, M.D.____Milwaukee
561 No. 15th Street
S. J. Graiewski, M.D._____Oshkosh
316 Main Street
D. L. Williams, M.D._____Madison
16 No. Carroll Street
Harold Cook, M.D._____Milwaukee
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208 East Wisconsin Avenue
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Nervous & Mental Diseases
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Public Assistance
257 No. Madison Street
Ray Piaskoski, M.D._____Wood
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3245 No. Lake Drive
R. B. Windsor, M.D._____Sheboygan
Safe Transportation
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Chest Diseases
River Pines Sanatorium
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School Health
1011 No. 8th Street
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Visual & Hearing Defects
2040 W. Wisconsin Avenue

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30 So. Henry Street

AN OPPORTUNITY FOR A YOUNG AMERICAN GENERAL PRACTITIONER

An excellent opportunity exists for a young American general practitioner with an interest in surgery, to work with the famed Burma Surgeon, Dr. Gordon S. Seagrave, at his 250-bed hospital in Namkham, Burma. Minimum appointment is for two years. With satisfaction an extended tenure would be encouraged.

The candidate should be an American citizen of any race or religion but his age should not exceed forty. He may be married or single. If married to a trained nurse, there would be an important place for her in the nurses training program; or to a school teacher, an opportunity to teach in the secondary school on the hospital compound.

Extensive experience is not a requirement but graduation from an "A" class medical school is. Professional practice at the Namkham Hospital is intensive, widely varied and often rare to Western medical experience.

The candidate must be prepared to leave for Burma not later than the Spring of 1963, or sooner if possible (depending upon issuance of his visa) so that his appointment can overlap that of the American doctor now serving the program. This appointment offers a modest salary per annum. Travel expenses and Western style housing will be provided.

Anyone interested should please write: American Medical Center for Burma, Inc., 6 Penn Center Plaza, Philadelphia 3, Penn., stating qualifications, etc.

Recipients of the Council Award

Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

John M. Dodd, M.D.†	1930
Cornelius A. Harper, M.D.†	1930
John J. McGovern, M.D.†	1931
Louis M. Jermain, M.D.†	1931
Edward Evans, M.D.†	1931
Mina B. Glasier, M.D.†	1932
Arthur W. Rogers, M.D.†	1934
Rock Sleyster, M.D.†	1934
Olin West, M.D.†	1934
Edward A. Birge, Ph. D.**†	1935
Arthur J. Patek, M.D.†	1935
Joseph F. Smith, M.D.†	1937
Eben J. Carey, M.D.†	1938
William S. Middleton, M.D.	1938
Fred G. Johnson, M.D.†	1939
William D. Stovall, M.D.	1940
Ludvig Hektoen, M.D.***†	1941
Stephen E. Gavin, M.D.†	1944
F. Gregory Connell, M.D.	1947
E. R. Schmidt, M.D.†	1949
Armand J. Quick, M.D.	1950
F. A. Stratton, M.D.†	1951
Gunnar Gundersen, M.D.	1953
W. J. Meek, Ph.D.	1953
R. G. Arveson, M.D.†	1957
Edwin B. Fred, Ph.D.	1958
Harry Beckman, M.D.	1959
Elizabeth Comstock, M.D.	1961

** Then president of the University of Wisconsin and professor of zoology.
*** Centennial Award.
† Deceased.

Recipients of the Presidential Citation

The President of the State Medical Society, with the unanimous approval of the Council, has the privilege of presenting a Presidential Citation to a nonphysician who has made a significant contribution to medicine or public health.

Since the establishment of this citation in 1959, the following persons have been so recognized:

Reuben Knutson (Chairman, Wisconsin Industrial Commission	1959
Helen Crawford (Librarian, University of Wisconsin Medical School Library)	1962

REFER CHILD PLACEMENT CASES TO THESE AGENCIES

LICENSED CHILD WELFARE AGENCIES:

*Children's Service Society of Wisconsin, 610 North Jackson, Milwaukee 2.

Catholic Social Welfare Bureau, 207 East Michigan Ave., Milwaukee 2.

Catholic Welfare Agency, 1209 Hughitt, Superior.

Catholic Social Service, Inc., 128 South Sixth Street, La Crosse.

Catholic Welfare Bureau, 25 S. Hancock, Madison 3.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa 13.

Lutheran Welfare Society of Wisconsin, 3126 West Highland Boulevard, Milwaukee 8.

Jewish Family and Children's Service, 2218 North Third Street, Milwaukee 12.

PUBLIC AGENCIES:

*Wisconsin Division for Children and Youth, Room 385, State Office Bldg., Madison 2.

*Milwaukee County Department of Public Welfare, Child Welfare Division, County Court House, Milwaukee 3.

LICENSED MATERNITY HOMES:

Infant of Prague Maternity Home (Catholic), 304 Front Street East, Ashland.

*Martha Washington Home, 6306 Cedar Street, Wauwatosa.

Misericordia Hospital (Catholic), 1233 North 23rd Street, Milwaukee 3.

St. Francis Hospital (Catholic), 1020 Market Street, La Crosse (temporarily closed due to a building program).

St. Mary's Home (Catholic), 435 South Webster Avenue, Green Bay.

Fees for care in licensed maternity homes vary from $150 and up, depending on length of stay, covering prenatal care, confinement, and care after the child is born. Counseling services for unwed parents, both before and after the birth of the child, are provided by social agencies.

* Nondenominational.

Past Presidents of the State Medical Society

Mason C. Darling, Fond du Lac 1841–1847
J. B. Dousman, Milwaukee 1848, 1849
A. L. Castleman, Delafield 1850, 1851
Harmon Van Dusen, Mineral Point 1852, 1853, 1854
A. L. Castleman, Delafield 1855
John Mitchell, Janesville 1856
D. Cooper Ayres, Green Bay 1857
Clark G. Pease, Janesville 1858, 1859
E. S. Carr, Madison 1860, 1861
Solomon Blood, Rochester 1862

(No meetings held from 1863 through 1866; apparently no new officers).

Harmon Van Dusen, Mineral Point 1867, 1868, 1869
Solon Marks, Milwaukee 1870
H. P. Strong, Beloit 1871
John Favill, Madison 1872
Harmon Van Dusen, Mineral Point 1873
M. Waterhouse, Portage 1874
J. T. Reeve, Appleton 1875
J. B. Whiting, Janesville 1876
J. K. Bartlett, Milwaukee 1877
Darius Mason, Prairie du Chien 1878
Nicholas Senn, Milwaukee 1879
J. G. Meachem, Sr., Racine 1880
Ira Manley, Jr., Markesan 1881
William Meacher, Portage 1882
T. P. Russell, Oshkosh 1883
N. M. Dodson, Berlin 1884
E. W. Bartlett, Milwaukee 1885
G. M. Steele, Oshkosh 1886
S. C. Johnson, Hudson 1887
L. G. Armstrong, Boscobel 1888
J. R. Barnett, Neenah 1889
E. M. Rogers, Hartford 1890
G. D. Ladd, Milwaukee 1891
G. F. Witter, Grand Rapids, Mich. 1892
B. T. Phillips, Menominee, Mich. 1893
B. C. Brett, Green Bay 1894
Almon Clarke, Sheboygan 1895
F. W. Epley, New Richmond 1896
B. O. Reynolds, Lake Geneva 1897
William Mackie, Milwaukee 1898
Herman Reineking, Milwaukee 1899
W. T. Sarles, Sparta 1900
J. F. Pritchard, Manitowoc 1901
W. H. Neilson, Milwaukee 1902
J. V. R. Lyman, Eau Claire 1903
F. E. Walbridge, Milwaukee 1904
C. W. Oviatt, Oshkosh 1905
J. R. Currens, Two Rivers 1906
L. H. Pelton, Waupaca 1907
W. E. Ground, Superior 1908
Gilbert E. Seaman, Madison 1909
Edward Evans, La Crosse 1910
Byron M. Caples, Waukesha 1911
John M. Dodd, Ashland 1912
Arthur J. Patek, Milwaukee 1913
Charles S. Sheldon, Madison 1914
T. J. Redelings, San Diego, Cal. 1915
L. J. Jermain, Milwaukee 1916
Hoyt E. Dearholt, Milwaukee 1917
Gustave Windesheim, Kenosha 1918
D. J. Hayes, Milwaukee 1919
C. R. Bardeen, Madison 1920
H. W. Abraham, Appleton* 1921
M. A. McGarty, La Crosse 1921
S. Hall, Ripon 1922
F. G. Connell, Oshkosh 1923
Rock Sleyster, Wauwatosa 1924
Wilson Cunningham, Platteville 1925
Joseph F. Smith, Wausau 1926
Arthur W. Rogers, Oconomowoc 1927
John J. McGovern, Milwaukee 1928
Karl W. Doege, Marshfield 1929
F. J. Gaenslen, Milwaukee 1930
A. J. McDowell, Soldiers Grove** 1931
C. A. Harper, Madison 1931
Otho Fiedler, Sheboygan 1932
Reginald H. Jackson, Madison 1933
Stanley J. Seeger, Texarkana, Texas 1934
T. J. O'Leary, Superior 1935
R. M. Carter, Green Bay 1936
Stephen E. Gavin, Fond du Lac 1937
James C. Sargent, Milwaukee 1938
A. E. Rector, Appleton 1939
R. G. Arveson, Frederic 1940
R. P. Sproule, Milwaukee 1941
Gunnar Gundersen, La Crosse 1942
F. E. Butler, Menomonie 1943
R. M. Kurten, Racine 1944
Charles Fidler, Milwaukee 1945
P. R. Minahan, Green Bay 1946
C. A. Dawson, River Falls 1947
W. D. Stovall, Madison 1948
K. H. Doege, Marshfield 1949
J. W. Truitt, Milwaukee 1950
H. H. Christofferson, Colby 1951
A. H. Heidner, West Bend 1952
J. C. Griffith, Milwaukee 1953
H. Kent Tenney, Madison 1954
Arthur J. McCarey, Green Bay*** 1955
Ervin L. Bernhart, Milwaukee 1956
L. O. Simenstad, Osceola 1957
Harry E. Kasten, Beloit 1958
Jerome W. Fons, Milwaukee**** 1958
W. B. Hildebrand, Menasha 1960
E. D. Sorenson, Elkhorn 1961
L. H. Lokvam, Kenosha 1962

* Died during term of office as president-elect.
** Resigned, because of health, prior to taking office.
*** Through April, 1955. The date of the Society's Annual Meeting, at which the president is elected, was changed from October to May during this year.
**** Resigned during term of office.

The State Medical Society of Wisconsin

ORGANIZED 1841

N. A. HILL, Madison, President
W. J. EGAN, Milwaukee, President-elect
R. E. CALLAN, Milwaukee, Speaker
H. W. CAREY, Lancaster, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

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J. M. BELL, Marinette, Vice-chairman

Term Expires 1963

First District:
W. D. James.....Oconomowoc

Second District:
G. J. Schulz.....Union Grove

Term Expires 1965

Third District:
M. D. Davis.....Milton

Term Expires 1964

E. J. Nordby.....Madison

Term Expires 1963

J. H. Houghton.....Wisconsin Dells

Term Expires 1964

Fourth District:
E. M. Dessloch.....Prairie du Chien

Term Expires 1964

Fifth District:
P. B. Blanchard.....Cedarburg

Sixth District:
H. J. Kief.....Fond du Lac

Term Expires 1965

George Nadeau.....Green Bay

Seventh District:
J. C. Fox.....La Crosse
(Chairman)

Eighth District:
J. M. Bell.....Marinette
(Vice-chairman)

Ninth District:
R. W. Mason.....Marshfield

Tenth District:
R. C. Frank.....Eau Claire

Term Expires 1963

Eleventh District:
V. E. Ekhlad.....Superior

Twelfth District:
L. J. Van Hecke.....Milwaukee
W. J. Houghton.....Milwaukee

Term Expires 1964

D. M. Willson.....Milwaukee

Term Expires 1965

S. L. Chojnacki.....Milwaukee
S. W. Hollenheck.....Milwaukee

Thirteenth District:
W. P. Curran.....Antigo

Term Expires 1963

L. H. Lokvam.....Kenosha
(Past President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

L. O. Simenstad, Osceola, 1964
E. L. Bernhart, Milwaukee, 1964
R. E. Galasinski, Milwaukee, 1963
A. A. Quisling, Madison, 1963

Alternates

John M. Bell, Marinette, 1964
C. J. Picard, Superior, 1964
George Collentine, Jr., Milwaukee, 1963
W. B. Hildebrand, Menasha, 1963

The Wisconsin Medical Journal, Official Publication
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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	Wm Smiles 522 W. 2nd St., Ashland	C. A. Grand 206–6th Ave., W., Ashland	
Barron–Washburn–Sawyer–Burnett	Robert M. Anderson Cumberland	Joseph E. Powell Chetek	Second Tuesday 7:30 p.m.
Brown	John E. Dettman 519 S. Monroe Green Bay	Frank Urban Rm. 308, City Hall, Green Bay	Second Thursday*
Calumet	K. R. Humke Chilton	R. E. Knauf Chilton	
Chippewa	G. C. Shonat 100½ Bridge, Chippewa Falls	C. T. Bowe Cadott	Second Tuesday
Clark	Raymond L. Hansen Colby	E. Dolf Pfefferkorn Colby	
Columbia–Marquette–Adams	Fred Gissal Wisconsin Dells	H. L. Conley Wisconsin Dells	Every Third Month 7:00 p.m.
Crawford	M. S. Garrity 610 East Taylor St., Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	R. N. Allin 1313 Fish Hatchery Rd. Madison	Gordon Davenport 110 E. Main, Madison	Second Tuesday**
Dodge	Fred A. Karsten 514, E. Lake St., Horicon	Norman Ericksou 302 N. Spring St., Beaver Dam	Last Thursday*
Door–Kewaunee	Patricia Lanier Kewaunee	E. W. Wits 213 Ellis, Kewaunee	
Douglas	I. H. Lavine 216 Board of Trade Bldg., Superior	R. R. Mataczynski 1514 Ogden Ave., Superior	First Wednesday* Hotel Superior
Eau Claire–Dunn–Pepin	R. R. Richards 605 Walker Ave., Eau Claire	W. H. Walter 131 S. Barstow St., Eau Claire	Last Monday
Fond du Lac	D. W. McCormick 55 N. Portland St., Fond du Lac	W. G. Kendell 92 E. Division St., Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley, Waheno	D. V. Moffet, Crandon	
Grant	C. L. Steidinger Platteville	H. W. Carey Lancaster	Last Thursday, March, June. Sept. and Nov.
Green	W. J. Fencil 921 16th Ave., Monroe	B. H. Brunkow 921 16th Ave., Monroe	
Green Lake–Waushara	Grant Stone 124 N. Wisconsin, Berlin	L. J. Seward 147 N. State St., Berlin	Last Thursday, every other month starting in Jan.

* Except June, July and August. ** Except July and August

List of Officers and Scheduled Meetings of County Medical Societies (Continued)

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	Harold Breier Montfort	E. J. Hohler Mineral Point	First Thursday following first Monday
Jefferson	E. A. Miller 133 Riverlawn Ave. Watertown	J. S. Garman 144 W. Madison, Waterloo	Third Thursday*
Juneau	J. H. Vedner Mauston	Jack Strong Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	J. J. Lutz 1202 60th St., Kenosha	G. F. Armstrong 6530 Sheridan Rd., Kenosha	First Thursday* Elks Club
La Crosse	Karl Ruppenthal Bangor	Ruth Dalton St. Francis Hosp., La Crosse	Third Monday
Lafayette	R. E. Hunter Argyle	L. L. Olson Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	John McKenna 1125 Superior, Antigo	First Monday
Lincoln	J. D. Millenbah 121 S. Mill St., Merrill	E. O. Ravn, Jr. 1802 9th St., Merrill	
Manitowoc	R. G. Yost 918 Washington St. Manitowoc	S. L. Kaner 1421 17th St. Two Rivers	Last Thursday
Marathon	O. R. Kelley 803 3rd St., Wausau	George Kordiyak 126 Grand Ave., Wausau	
Marinette–Florence	A. Barrette 132 N. Emery St., Pesbtigo	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	R. A. Frisch 425 E. Wisconsin Ave., Milwaukee	W. C. Curtis 9128 W. North Ave., Wauwatosa Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milw.	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main St., Oconto	F. W. Klutzow Gillett	
Oneida–Vilas	Allen Johnson Rhinelander	Marvin Wright 1020 Kabel Ave., Rhinelander	Monthly
Outagamie	F. M. Hauch 519 W. College Ave., Appleton	Wm. Chandler 402 W. Wisconsin, Appleton	Third Thursday* Elks Club
Ozaukee	R. F. Henkle 549 W. Grand Ave., Port Washington	P. W. Wallestad 502 W. Jefferson, Port Washington	
Pierce–St. Croix	H. J. Laney Prescott	P. H. Gutzler River Falls	Third Tuesday
Polk	Donald Fink St. Croix Falls	Lloyd L. Olson St. Croix Falls	Third Thursday 7:00 p.m.
Portage	Austin Dunn 538 Main St., Stevens Point	Albert Kohn 313 N. Fremont Stevens Point	
Price–Taylor	Walter E. Niebauer Phillips	John L. Rens Phillips	Last Saturday, Feb., May, Aug., and Nov.
Racine	W. H. Williamson 1101 Grand Ave., Racine	L. E. Jones 431 15th St., Racine Mr. G. N. Geraghty 600 Villa Street, Racine Exec. Sec.	Third Thursday
Richland	R. W. Edwards 118 West Mill St. Richland Center	L. M. Pippin 323 South Central Ave., Richland Center	First Thursday Richland Hospital
Rock	Eugene Betlach Mercy Hospital, Janesville	W. A. Scholten 1146 Grant, Beloit	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	E. F. Pischke Box 365, Baraboo	R. G. Knight Reedsburg	Second Tuesday*
Shawano	H. C. Marsh 137½ S. Main, Shawano	A. J. Sebesta Shawano	Third Wednesday
Sheboygan	Willard G. Huibregtse 1011 N. 8th St., Sheboygan	J. F. Kovacic 708 St. Claire Ave. Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	Richard L. Holder 221 Main St., Black River Falls	J. H. Noble 1109 Harrison Black River Falls	Fourth Tuesday
Vernon	R. A. Starr 318 S. Main St., Viroqua	W. N. Otterson Westby	Last Wednesday
Walworth	Glenn Smiley 107 N. 3rd St., Delavan	J. B. Schrock Sharon	Second Thursday*
Washington	Wm. C. P. Hoffmann 57 S. Main St., Hartford	James Algiers P. O. Box 110, Hartford	Fourth Thursday
Waukesha	Eugene B. Frank Box 31, Ooonomowoc	W. E. Rosenkranz 720 N. Rochester, Mukwonago	First Wednesday
Waupaca	Sam Salan 105 Jefferson St., Waupaca	H. S. Caskey Clintonville	
Winnebago	Charles Behnke 421 Jefferson St., Oshkosb	E. J. Zmolek 302 N. Main St., Oshkosh	First Thursday
Wood	G. G. Shields P. O. 270, Wisconsin Rapids	John W. Rupel 650 S. Central, Marshfield	Four times a year

* Except June, July and August.

Officers of State Boards and Commissions

Wisconsin State Board of Health

MEMBERS OF THE BOARD

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Edward N. Vig, M.D. (1966) — Viroqua

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Irving J. Ansfield, D.O. (1968) — Milwaukee

Harold A. Bachhuber, M.D. (1969) — Sauk City

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Assistant State Health Officer — E. H. Jorris, M. D., M. S. P. H.

GENERAL ADMINISTRATION

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Division of Research	Vacancy	Director
Division of Business Management	Arthur E. Yuds, B.B.A.	Director
Division of Personnel	Richard J. Siesen, B. S.	Director
Division of Fiscal Services	Glenn B. Fischer, B.B.A.	Director
Division of Internal Services	Lenore Brandon	Supervisor
Division of Cosmetology	Kathleen Bower	Supervisor
Division of Barbering	Thomas D. Ritchie	Supervisor
Division of Funeral Directing & Embalming	Helen Kjelson	Supervisor

GENERAL SERVICES

E. H. Jorris, M.D., M.S.P.H. — Director

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Microfilm Laboratory	Duane A. Hambrecht	Supervisor
Statistical Services	Raymond D. Nashold, M. S.	Director
Division of Hospital and Related Services	Vincent F. Otis	Director
Division of Public Health Nursing	Ione M. Rowley, R. N., B. S.	Director

PREVENTABLE DISEASES

Milton Feig, M. D., M. P. H. — Director

Bureau of Communicable Diseases	Josef Preizler, M. D., M. P. H.	Director
Division of Venereal Disease Control	A. L. Van Duser, M. D., M. P. H.	Director
Division of Cancer Control	A. L. Van Duser, M. D., M. P. H.	Director
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(continued on next page)

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TAX GUIDE AVAILABLE

The Wisconsin Taxpayers Alliance has announced that the 1963 edition of TAXES, its annually published tax guide, is now available. TAXES provides easy-to-follow instructions on how to fill out both state and federal income tax returns. TAXES also includes information on all state and federal taxes levied in Wisconsin. The new tax changes made by congress and the Wisconsin legislature are incorporated in the 1963 edition. The book has been revised and includes additional information about the various taxes, such as the amount of revenue each tax raises.

Orders should be sent to the Wisconsin Taxpayers Alliance, Madison 3, Wisconsin. The cost is 50 cents a copy.

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Contributions to The Charitable, Educational and Scientific Foundation of the State Medical Society are tax deductible by the donor. Their use is supervised by an 89 member Board of Trustees and donors may earmark contributions for specific purposes. For information write to The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin, Box 1109, Madison 1, Wis.

MEDICOLEGAL INFORMATION

AVAILABLE

Individual physicians or county medical societies may wish to make use of several informational materials and speakers on topics relating to medical-legal problems of physicians.

FILMS

The following films are available upon request to the State Medical Society of Wisconsin. Please allow at least two weeks advance notice if possible. These films were produced by Wm. S. Merrill Co. under direction of the American Medical Association, American Bar Association and American Hospital Association.

"Medical Witness"—Dramatically illustrates use of medical witness in court, providing do's and don'ts for effective testimony. Black and white, sound, 30 minutes.

"Doctor Defendant"—Suggests how the physician can prevent professional liability suits; shows county medical society grievance committee in action. Black and white, sound, 30 minutes.

"Man Who Didn't Walk"—Legal and medical aspects of personal injury case. Shows lawyers for plaintiff and defendant as they establish evidence from physicians, pretrial conference, and summation to jury. Black and white, sound, 30 minutes.

"A Matter of Fact"—Discusses the need for an adequate medical examiners' system versus the presently common coroners' system. Black and white, sound, 30 minutes.

"No Margin for Error"—Portrays certain aspects of physician-hospital activity bearing upon professional liability. Black and white, sound, 30 minutes.

"Silent Witness"—Deals with the subject of chemical tests for intoxication and the introduction of the results of such tests in court. Black and white, sound, 30 minutes.

SPEAKERS

County medical societies interested in obtaining speakers on medicolegal subjects may contact the State Medical Society, Box 1109, Madison 1, Wisconsin (phone ALpine 6–3101), or the State Bar Association of Wisconsin, 402 West Wilson Street, Madison, Wisconsin (phone ALpine 7–3838).

LITERATURE

Copies of the following materials are available upon request to the State Medical Society of Wisconsin:

★ Interprofessional Code

★ Medicolegal Consent Forms (see January 1958 Blue Book issue of the *Wisconsin Medical Journal*)

★ Test Your A. Q. (Alcohol Quotient), 20 Questions on alcohol

★ Malpractice and the Physician

★ Medicolegal Aspects of Blood Transfusions

★ Medicolegal Aspects of Blood Grouping

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

"March of Medicine" is in its eighteenth consecutive year of radio broadcasting. The programs, which are tape recorded, feature H. Kent Tenney, M.D., discussing various health problems with a lay person who is called "Your Medical Reporter." At present 54 stations in Wisconsin are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Day*	*Time*
WATK	Antigo	Saturday	8:45 a.m.
WATW	Ashland	Saturday	11:15 a.m.
*WLBL	Auburndale	Wednesday	9:15 a.m.
WWIS	Black River Falls	Saturday	9:10 a.m
*WHSA	Brule	Wednesday	9:15 a.m.
*WHKW	Chilton	Wednesday	9:15 a.m.
WAXX	Chippewa Falls	Saturday	11:45 a.m.
*WHWC	Colfax	Wednesday	9:15 a.m.
*WHAD	Delafield	Wednesday	9:15 a.m.
WBIZ	Eau Claire	Sunday	6:45 p.m.
WERL	Eagle River	Saturday	9:45 a.m.
KFIZ	Fond du Lac	Thursday	7:15 p.m.
WJPG	Green Bay	Saturday	8:45 a.m.
WTKM	Hartford	Tuesday	4:45 p.m.
WHSM	Hayward	Saturday	10:00 a.m.
*WHHI	Highland	Wednesday	9:15 a.m.
*WHLA	Holmen	Friday	10:30 a.m.
WCLO	Janesville	Tuesday	8:15 p.m.
WLIP	Kenosha	Saturday	9:10 a.m.
WLDY	Ladysmith	Saturday	9:00 a.m.
WHA	Madison	Wednesday	9:00 a.m.
*WHA-AM	Madison	Wednesday	9:00 a.m.
*WHA-FM	Madison	Wednesday	9:00 a.m.
WIBA	Madison	Saturday	11:15 a.m.
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WMAM	Marinette	Sunday	10:30 p.m.
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WIGM	Medford	Saturday	9:45 a.m.
WEKZ	Monroe	Saturday	1:45 p.m.
WXMT	Merrill	Tuesday	2:15 p.m.
WMNE	Menomonie	Tuesday	9:45 a.m.
WNAM	Neenah	Sunday	7:05 p.m.
WCCN	Neillsville	Saturday	9:00 a.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Saturday	11:15 a.m.
WPDR	Portage	Thursday	10:45 a.m.
WIBU	Poynette	Thursday	2:35 p.m.
WWCF-FM	Poynette	Sunday	3:45 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:30 p.m.
WRDB	Reedsburg	Saturday	12:45 p.m.
WOBT	Rhinelander	Saturday	10:15 a.m.
WJMC	Rice Lake	Saturday	9:45 a.m.
WCWC	Ripon	Saturday	9:00 a.m.
WTCH	Shawano	Sunday	6:15 p.m.
WDOR	Sturgeon Bay	Tuesday	9:05 a.m.
WQMN	Superior	Saturday	11:15 a.m.
WTMB	Tomah	Wednesday	3:00 p.m.
WTRW	Two Rivers	Wednesday	11:00 a.m.
WISV	Viroqua	Saturday	8:45 a.m.
WTTN	Watertown	Friday	11:30 a.m.
*WHRM	Wausau	Friday	10:30 a.m.
WSAU	Wausau	Saturday	5:15 p.m.
WBKV	West Bend	Saturday	11:15 a.m.

* Radio stations in the state network.

THE PRESIDENT'S PAGE . . .

The Shrine Burn Center for Children

The Zor Shrine Temple of 5,000 members and officials is developing a project very dear to their hearts. The Imperial Shrine during its annual meeting in Toronto, Canada, appropriated ten million dollars to establish the first of three hospitals "for the care and treatment of curable crippled children with acutely dangerous burns, and for the research activities and training programs related thereto."

It has been proposed that the first of the three hospitals be located centrally. The others would be located one on the East and one on the West Coast. The first center plans to house approximately 35 beds and associated laboratory, research, and clinical facilities at the cost of $3,000,000 with $1,250,000 contributed annually for the estimated cost of maintenance. All this is part of an international program for the treatment of child burn cases.

Several cities in the United States are qualified to be the home of the first center. But Zor Temple believes Madison, Wisconsin, is eminently qualified. Acting Dean Philip P. Cohen of the University of Wisconsin Medical School has already outlined the facilities of the University Medical Center and invited the National Committee to consider the possibility of developing a burn center here with the full cooperation of our internationally famous educational and research center. Committee members have been invited to visit Madison and see the facilities for themselves.

Zor Temple is one of the youngest temples, founded in 1933, but has one of the best records in membership and activities.

Every practicing physician in Wisconsin endorses the efforts of Zor Temple and the University Medical Center to marshall all the facts about the advantages of Madison, Wisconsin, as the location for the first Shrine burn center for children. The medical profession of Wisconsin has always supported education in our state. The active participation of many members as preceptors since this method was instituted by the University of Wisconsin Medical School has not only shown interest and cooperation but also has made substantial contributions to medical education in this state.

The Shrine Hospitals for Crippled Children have long been a valuable asset to national health. The proposed Burn Centers are equally unique and offer the opportunity for great advances in the knowledge of the physiology, genetics, biochemistry, and treatment of burns.

The State Medical Society of Wisconsin endorses the efforts of the Zor Temple of Madison and offers its full cooperation in the establishment of the proposed Burn Center.

N. A. Kieg, M.D.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

JANUARY 1963

Vol. 62 No. 1

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D. N. GOLDSTEIN, M. D., *Editorial Director*

Our Sixtieth

WHEN A PUBLICATION reaches its sixtieth year, a prideful backward glance for the sake of "auld lang syne" may be forgiven. Longevity in journalism is in itself remarkable; and if a publication persists without the sustaining impetus of private profit, it is all the more entitled to a little self-congratulation. Retrospection, however, even for sexagenarians, is futile unless it relates to the present and indicates for the future.

The *Wisconsin Medical Journal* can point to a history of service to the medical profession and to the people of Wisconsin. One of the major functions of the magazine has been the dissemination of medical knowledge through the publication of scientific papers, particularly by Wisconsin physicians. The *Journal* has brought to the state's doctors the proceedings of clinical-pathological conferences in hospitals in the state. It has kept physicians current on developments in the science of pharmacology and related disciplines. The *Journal* has reported on the areas of medical education, economics, legislation and public health. In a very real sense, the *Journal* has served Wisconsin doctors as a window on the constantly changing panorama of medicine, with particular emphasis on what is happening close to home.

Before the *Wisconsin Medical Journal* started publishing, in January 1903, the State Medical Society had resolved, by unanimous vote, to publish the transactions of the Society in the magazine, thus making it its official organ, even though the magazine was at that time the property of a group of physicians organized as the Wisconsin Medical Journal Company. Since then, news of the State Medical Society has constituted an important element of the editorial content of the publication. Official actions of the Society, expression of membership opinion, news of members of the Society and material of historical significance have been faithfully and honestly reported to the readers of the magazine. A long list of features of special interest to State Medical Society members, as well as to nonmember doctors, appear regularly in the *Journal*, regarding such varied topics as ethics, record-keeping, patient-relations, insurance, tax regulations, retirement programs, child adoption procedures, community and professional relations and many

others. Thus, the *Journal* through the years has functioned effectively as an official organ of its sponsoring organization.

As a scientific magazine, the *Journal* could easily have become merely a regional, monthly compendium of learned papers—a convenient medium of publication. It could have narrowed its scope and aimed only at the restricted professional interest of the doctor. Or, conversely, it could have become primarily a mouthpiece for an organization, and what scientific articles it presented could have been offered with the uncritical redaction that characterizes some other regional professional magazines. Thanks, however, to a series of conscientious, hard-working, scientific editors of towering integrity, starting with Dr. Arthur J. Patek in 1903, and continuing through the Doctors Doege of Marshfield and Dr. R. S. Baldwin of Marshfield to the present medical editor, Dr. V. S. Falk, Jr., the *Journal* has maintained high standards of scientific journalism. At the same time, the *Journal* has never compromised its view that the doctor is more than a plodding practitioner of the healing art and that he desires information supporting the total exercise of an infinitely varied and complex profession. Thus, the *Journal* has developed a characteristic format and its own personality. It has a face and a form distinctively its own, characterized by what we think is integrity, honesty and fairness.

The editorial that introduced the first issue of the *Wisconsin Medical Journal* enunciated a policy that the magazine has attempted to follow for 60 years: "We will aim . . . to avoid the shoals of factional strife, to court no 'entangling alliances', but to encourage and recognize good work wherever it is being carried on." The avoidance of "factional strife" may have been possible for a publication in 1903, although we doubt it. In the relatively simple society of six decades ago, a doctor could conceivably practice medicine and devote himself only to the technical aspect of his profession. Medicine then was not thought to be a social benefit guaranteed all citizens. In the early years of this century there were no workmen's compensation laws, no income taxes, no intrusion of nonmedical considerations into the exercise of our vocation.

History has altered the manner of our living. Two world wars, the technological revolution of the nuclear era, the emergence of political fascism and the spread of communism as a tool of Russian imperialism, the changing concept of government as a guarantor of social welfare, and many other changes in the last sixty years have cancelled even the possibility of the doctor remaining aloof from the unfolding life of his community. Few community problems are removed from the practice of medicine, nor can we consider the treatment of a patient's physical ills as something apart from his total welfare. As social planners consider the community aspects of the practice of medicine to be the legitimate subject of their consideration, so doctors should consider social planning to be the legitimate subject of their consideration. Indeed, in our democracy, the welfare of the community is the business of every member of the community, and we have a responsibility as educated, responsible citizens to give the community the benefit of our social thinking as well as our technical skill.

To believe a medical journal can avoid the "shoals of factional strife" today is to wear the blinders we removed from the eyes of our horses of the 1903 period. We oppose tax-supported medicine; we favor extension of the laws controlling quacks; we try to regulate many of the services affecting our practice. We are in politics to that extent. But having engaged in "factional strife" on certain issues, it is unthinkable that we should limit ourselves only to those issues that affect us in our professional being. We are, like all other Americans, citizens of this country, and what affects us as citizens also affects us as doctors. If it were possible in 1903 to pretend a political schizophrenia, certainly our experience of the last four decades has proven to us that we must integrate our professional and personal lives.

Organized medicine is not a monolithic mass; differences of opinion do exist, especially in areas of political thought and social planning. The differences are legitimate and, providing they are based on reason, healthy. But no publication of vigorous personality, no journal with any spirit can hope to express all shades of opinion or none of them. It must take a stand, and the position it assumes dictates its policy with regard to all questions, professional and political. If we oppose tax-supported medicine, we must consistently reject all government intrusion in areas presently serviced adequately by private enterprise. If we favor democracy, we

must consistently oppose the enemies of democracy.

As the *Wisconsin Medical Journal* receives congratulations and good wishes on its sixtieth birthday, we can applaud its service to doctors in their professional capacity. At the same time, we can anticipate a growing awareness of its role not only as teacher but also as conscience to organized medicine in Wisconsin. Readers may not always agree with the editorial opinions of the *Wisconsin Medical Journal*, but they must appreciate an obligation to state problems of the day and to entertain a viewpoint. There may be controversy, but there will also be vitality. And as long as there is vitality this *Journal* will grow and prosper in its total service to the doctor.

Many happy returns, dear old *Wisconsin Medical Journal*, official organ of the State Medical Society of Wisconsin! Happy birthday to you!—D. N. G.

Parsimony in Dairyland

If the general public supported medical causes as Wisconsin doctors supported their own Charitable, Educational and Scientific Foundation, medical progress would be severely retarded. For whatever reasons, the recent appeal for funds, which started with the Foundation's fiscal year—July 1962, produced $11,769.50 by January 15, 1963, with about 14 per cent of the doctors in the state contributing an average of slightly more than $22. At this rate the State Medical Society Foundation could easily fail.

The entire disgraceful story was spelled out by Dr. William D. Stovall's letter to the membership of the Society in December. While the statewide picture was black enough, the report of the charitable inclinations of doctors in three of the largest—and perhaps richest—county societies was nothing less than appalling. By the middle of January Kenosha, Racine and Milwaukee counties, which represent over 41 per cent of the total membership, managed to come up with a meager $2,108, or less than 12 per cent of the total contributed. The average contribution in these counties was only $13.87, given by 152 doctors, or 29 per cent of those in the entire State who did make a donation.

Elsewhere the record is just as bad. Of the 67 doctors in Wood County only five were sufficiently impressed with the good work done by the Foundation to make a contribution. Only one doctor in the Door–Kewaunee, Iowa, Juneau, Oconto, and Rusk societies contributed; none contributed in Forest County. Only in the Vernon and Marinette–Florence county societies was the response more than 50 per cent; in Vernon eight out of the 15 members donated an average of $15 each and in Marinette–Florence—one of the Foundation's most loyal supporters—all 16 of its regular members contributed $40 each.

It is inconceivable that Wisconsin physicians are deaf to an appeal by a cause most intimate to their welfare as well as to their own brand of social service. The kindest explanation for the poor showing made by the CES Foundation appeal is that it came at a time when doctors may have been swamped by requests for money on behalf of other charities. If this is so, it would be well to examine closely the merits of the charities we are supporting to determine whether we can afford to permit the Foundation to go down the drain for their sake. Clearly, we cannot support every cause that appeals to our generosity. When a choice must be made, we must make it on the basis of its value to us and to our Society. On this basis the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin yields to no other cause.

It is not too late to contribute to the CES Foundation. The need for funds is great, and contributions are as tax deductible in 1963 as they were in 1962. It is to be hoped that many Wisconsin physicians will reconsider the appeal of the Foundation and send the gift of money that is required by the merit of the cause and by the demands of their own conscience.—D. N. G.

Value of Advertising

If there were no pharmaceutical advertising, new lifesaving drugs would be withheld from the critically ill patients, either because we the physicians did not know the new drug existed or we did not know its exact indications and how to administer it safely and effectively. The pharmaceutical industry is having to carry the Herculean load of protecting its livelihood, and providing the world with these lifesaving remedies.—TROY A. SHAFER, M. D., Chairman, Board of Trustees, Texas Medical Association, in *Texas State Journal of Medicine*, October 1962.

THE MEDICAL FORUM

Comprehensive Work Week of Health Planned

The Wisconsin Work Week of Health—a series of conferences to assess current status and future planning in a number of health areas—will be held February 18 to 23 at the State Medical Society headquarters in Madison.

The five days of meetings will cover topics of interest to physicians, other members of the health team, and the general public.

Fifteen out-of-state speakers will join Wisconsin leaders in discussion of school health, public and rural health, senior citizens, occupational health, medical education and hospitals, and interprofessional matters.

There also will be special meetings of various medical society committees and statewide organizations during the week. It will conclude with the annual conference of presidents and secretaries of county medical societies on Saturday.

Meetings of particular interest to physicians will be:

- A Monday afternoon program on health appraisals of school children.
- A morning program on Tuesday on the senior citizen and health.
- A full day's program on occupational health on Wednesday, with general presentations in the morning and a plant tour and scientific program in the afternoon.
- Interprofessional Day on Friday, with discussion of many medical-legal topics.

The remaining programs also have much information to offer to the physician. These include a program on public and rural health on Tuesday afternoon and one on medical education and hospitals on Wednesday afternoon.

A special session, on an invitational basis, will be held for hospital administrators and chiefs of staffs on Thursday.

All sessions, with the exception of the afternoon occupational health program, will be held in the newly completed Presidents' Room at the State Medical Society headquarters in Madison.

"The Wisconsin Work Week of Health represents one of the most ambitious undertakings ever attempted by the State Medical Society to inform both physicians and the public and to initiate action in

(continued on next page)

Physicians Staff Emergency Hospitals; Others Needed

Fifty-six 200-bed emergency hospitals are currently prepositioned in 44 Wisconsin counties. Physicians are serving as chiefs-of-staff for 26 of the units, but more are needed to staff the remaining 30 units.

Shortly after "Operation Alert 1956" indicated the serious need of hospital facilities in case of disaster, 12 improvised hospital units to be dispersed in the area around Milwaukee county were accepted by the State Medical Society's Committee on Civil Defense. Additional units, which are provided by the federal government and are valued at $25,000 each, were accepted as they became available and placed in communities varying from 15 to 50 miles from critical target areas.

Each unit contains 200 portable beds, operating facilities and instruments, a shock treatment room, x-ray facilities, a pharmacy and allied supplies. Each unit requires 15,000 square feet of storage space.

Physicians who are serving as chiefs-of-staff and their counties include: Drs. E. A. Meili, Buffalo; Robert Cooney and Rolf F. Poser, Columbia; V. W. Nordholm, Dane; Norman W. Erickson, Dodge; John T. Murphy, Door; Ralph Anderson, Douglas; Otto A. Dittmer, Fond du Lac; Benjamin H. Brunkow, Green; W. A. Himmelsbach, La Crosse; John Garritty, Langlade; Norman Erdman, Nathan Davis, John D. Lynch and Robert C. Puestow, Manitowoc; G. F. Pratt, Oneida; Steve Osicka, Portage; Lief W. Erickson, Racine; George H. Thomson and John J. Tordoff, Rock; Donald M. Rowe and Lloyd J. Steffan, Sheboygan; R. S. Galgano, Walworth; L. J. Olson and D. J. Welter, Washburn; Leslie H. Stone and R. C. Wolfgram, Winnebago; and R. S. Baldwin and Robert L. Johnson, Wood.

Counties which have unstaffed units are: Ashland, Barron, Calumet, Chippewa, Crawford, Dodge (1), Dunn, Eau Claire, Fond du Lac (2), Iowa, Jefferson (2), Marathon, Oconto, Outagamie, Ozaukee, Polk, Price, Richland, St. Croix, Sauk, Shawano, Vernon, Walworth (1), Washington (2), Waukesha, Waupaca and Waushara.

LEGISLATIVE GUIDE

In this issue of the *Forum* are tables and maps listing Wisconsin's lawmakers, both at the statehouse in Madison and the capitol in Washington. They will serve as handy guides during the legislative sessions.

Comprehensive Work Week of Health Planned

(continued from page 101)

a wide field of health topics," said Dr. N. A. Hill, Madison, president of the State Medical Society.

A brief outline of the programs follows:

Health Appraisal of School Children

Mon., Feb. 18, 1:30–5:15 p. m.

A physician, a dentist, a public health official, a school administrator and a parent will discuss their roles and responsibilities. A special feature will be a closed circuit television program from the University of Wisconsin Medical School on "Developmental Phases of Children." Fred V. Hein, Ph.D., director of the department of health education of the American Medical Association, will conclude the program with a presentation on "Making the Medical Appraisal a Learning Experience."

The Senior Citizen and Health

Tues., Feb. 19, 9:30 a. m.–12:15 p. m.

R. W. Bardwell, chairman of the State Commission on Aging, and N. A. Hill, M.D., president of the State Medical Society, will be joined by three out-of-state speakers in discussing attitudes and values toward aging, a basic health program for the aged, insurance, the government role, and home care programs.

Speakers will be Theodore G. Klumpp, M.D., president of Winthrop Laboratories, New York City; Tom H. Alphin, M.D., medical director of Equitable Life Assurance Society, also of New York; William H. McBeath, M.D., of the Kentucky State Department of Health; and Wilbur J. Schmidt, director of the Wisconsin Department of Public Welfare.

Public Health and Wisconsin

Tues., Feb. 19, 2–5:15 p. m.

A varied program will be offered on such topics as medical schools and their role in rural health, health fairs, news media, nutritional quackery, strengthening of local health services, and the health and safety of youth.

Wisconsin Industry and Health

Wed., Feb. 20, 9 a. m.–5 p. m.

Attorney John A. Lawton, Madison; George E. Gullen of American Motors Corporation; and Reuben G. Knutson of the Industrial Commission will review the roles of labor, the employer, and the state in protecting the health of the worker during a morning general session.

An afternoon program for physicians will include a tour of Gisholt Machine Company, Madison, and a scientific program on such topics as prevention of occupational dermatitis, reemployment of the handicapped worker, and strain and effort in relation to coronary heart disease.

Speakers will be Donald M. Ruch, M.D., Milwaukee; Gordon Peterson, M.D., medical director of Kimberly-Clark Corporation; and Howard B. Sprague, M.D., Brookline, Mass.

A concurrent afternoon program for nurses will include a tour of Central Colony with a presentation of the employee health service department and an industrial health demonstration at Madison Kipp Corporation.

Medical Education and Hospitals

Wed., Feb. 20, 2–5 p. m.

Wisconsin's need for more physicians, residents and dentists will be discussed by T. H. McDonell, M.D., Waukesha; R. E. Galasinski, M.D., Milwaukee; and L. O. Skallen, D.D.S., Stoughton. Topics also include the management of pharmacies in both large and small hospitals and a presentation on the hospital employee health program.

Clinic Managers Program

Wed., Feb. 20, 9:30 a. m.–5 p. m.

Clinic managers will participate in the occupational health and medical education and hospitals programs and then hold separate sessions in the late afternoon and evening.

Institute for Hospital Administrators and Chiefs of Staff

Thurs., Feb. 21, 8:30 a. m.–5 p. m.

This special program will be presented to a limited number of administrators and physicians, by invitation. It will cover accreditation, legal status of staff appointments, administrator-medical staff relationships, and a series of afternoon workshops.

Interprofessional Day

Fri., Feb. 22, 9:30 a. m.–5 p. m.

A wide variety of topics of interest to licentiates in the health field and attorneys will feature speakers from the American Medical Association and Wisconsin professional leaders.

Informed surgical consent, legal implications of interrelations of physicians and other licentiates in patient care, professional liability insurance, and a study of the rule-making powers of state agencies will be covered in the morning session.

The Medical Practice Act, the nursing law, joint problems of physicians and attorneys in the trial of a lawsuit, state and federal laws governing physician retirement programs, and investigation of causes of death will be discussed in the afternoon.

Speakers will include William J. McAuliffe, Jr. and Arnold J. Streich of the American Medical Association staff; John Kluwin, Milwaukee, president of the State Bar of Wisconsin; attorneys Ralph M. Hoyt, Milwaukee, Wade Boardman, Madison, and Ben Salinski, Sheboygan; and L. J. Van Hecke, M.D., Milwaukee.

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Propose Specialized Training of OB Nurses

A two-week curriculum for a pilot study at St. Joseph's Hospital, Milwaukee, in specialized training of obstetrical nurses was proposed by the Scientific Committee of the Council of the State Medical Society at a meeting December 1, 1962, at the Milwaukee Athletic Club, Milwaukee, and recommended to the Executive Committee of the Council.

Dr. John R. *Evrard*, chairman of the Division on Maternal and Child Welfare of the Commission on State Departments, explained that the proposed project was an outgrowth of the Maternal Mortality Survey, and the feeling of those associated with the Survey that hospitals need an obstetrical nurse who has more training than most nurses have in that area, to meet specific emergencies when the doctor is not available. He emphasized the fact that the purpose was not to train midwives, but rather to make the nursing service in hospitals of more value to the medical staff.

The Committee further recommended that as soon as possible after the pilot study is completed the Council be provided a report and an outline of how the project could be made statewide if the pilot study is judged to be successful. The study was tentatively set for the middle of February.

In other actions the Committee approved a medical writing award, a medical photography contest, and a special "Marquette Issue" of the *Wisconsin Medical Journal* following the annual meeting. It also approved sending a special letter of thanks to Dr. F. E. Shideman for his services to the Society as joint author of the "Comments on Treatment" page in the Journal prior to his leaving the state in September, 1962.

Committee members present at the meeting included Drs. John M. Bell, Marinette; H. J. Kief, Fond du Lac; Stanley W. Hollenbeck and William J. Houghton, Milwaukee. Others present were Dr. William J. Egan, Milwaukee, president-elect of the State Medical Society, and Doctor Evrard.

News Briefs

"GOLDEN APPLE" FOR DR. POWELL

For his efforts in providing training and leadership to young medical students, Dr. Joseph Powell, Chetek, was presented the "Golden Apple" award of the Student A.M.A. Mr. James Brooks, president of the student organization, made the presentation.

Prof. James Crow Is New Acting Dean of UW Medical School

Prof. James F. Crow, chairman of the University of Wisconsin department of medical genetics, became acting dean of the University of Wisconsin Medical School January 7. He replaced Dr. Philip P. Cohen who had asked to be relieved of his duties as acting dean so that he might return to his teaching and research.

Professor Crow, a member of the National Academy of Sciences, is internationally known for his studies of genetics theory and radiation.

Only candidates from outside the present faculty are being considered for the permanent appointment to the deanship and chairmanship of the surgery department, in accordance with the principles established by the faculty advisory committee and the late Pres. Conrad Elvehjem.

"Citizens Band" Radio National Group Forms

Physicians who utilize "citizens band" two-way radio systems will be interested in the formation of a national organization called REACT.

It has been formed to:

1. Provide a round-the-clock radio communications system effectively supplenting police, fire, ambulance, hospital and civil defense efforts.
2. Promote correct and efficient use of "citizens band" radio.

REACT is already functioning in Wisconsin, and is being expanded to all 50 states. In addition to physicians, those using the personal two-way radios are policemen, firemen, ambulance operators, businessmen, newsmen, farmers and sportsmen.

Citizens radio was created in 1949 to satisfy a need for good, low-cost, two-way radio transmission by businessmen. Any citizen over 18 years of age may operate a private citizens band communications system upon application and receipt of his free radio station license.

Units are installable in home, office or auto, and have an effective range of five to 10 miles.

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Waukesha, 1st	Vincent R. Mathews (D)	530 Linden St., Waukesha

(Continued on next page)

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(continued from page 104)

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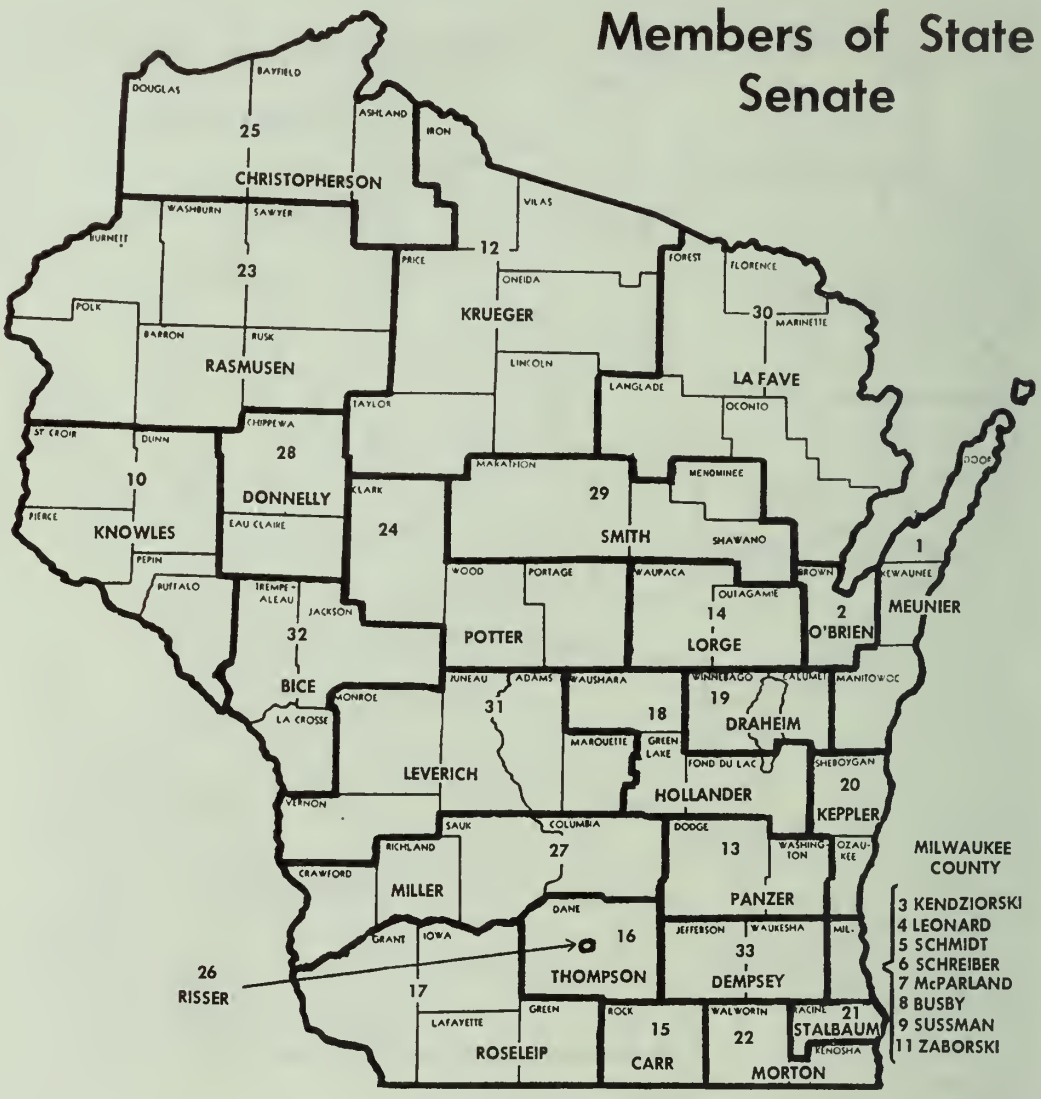

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Commission on Aging Supports Principle of Kerr-Mills Plan

A boost for Kerr-Mills implementation in Wisconsin came recently from the Governor's Commission on Aging when they expressed support in principle for "a program which will provide medical assistance to the group of marginal aged persons who are able to meet ordinary expenses but who cannot meet unusual medical costs."

The Commission backed complete medical assistance for those over 65 who:

1. Are ineligible for Old Age Assistance.
2. Have incomes which do not exceed $2,700 per year if married, or $1,800 per year if single.
3. Do not have liquid assets in excess of $7,500 if married and $4,500 if single.

The three criteria follow the provisions of Substitute Amendment 4A to Bill 550,A., introduced in the last session of the Legislature. The only difference is in the income levels; the bill proposed $1,500 for a single person and $2,500 for married couples.

The Commission also instructed Executive Director James McMichael, Madison, to ascertain if any new bill contained provisions that:

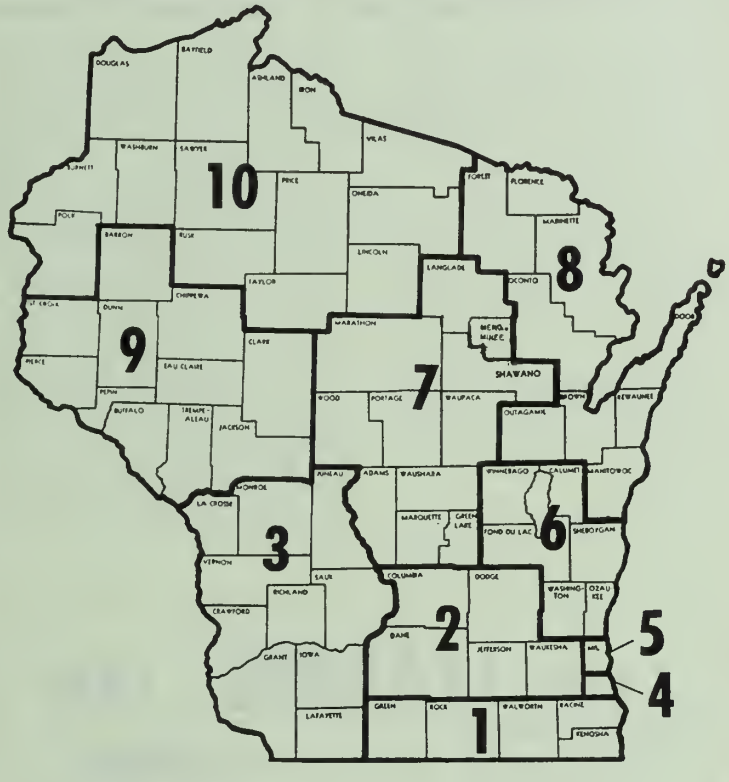
1. Clearly exempted homesteads, household possessions, and personal items, including automobiles, from personal assets.
2. Did not contain a lien law, but could contain a recovery clause on death of the recipient and the spouse.

Members of the Governor's Commission on Aging are Richard W. **Bardwell**, Madison, chairman; Dr. Patricia F. Lanier, Kewaunee, vice-chairman; Stanley J. **Gregory**, Milwaukee; Albert Blumenthal, Eau Claire; Milo K. Swanton, Madison; Curtis B. Gallen**beck**, Milwaukee, and Max **Taglin**, Milwaukee.

Heart Fund Leaders Named

Dr. William B. **Hildebrand**, Menasha, 1963 state Heart Fund chairman, will be assisted by Dr. Leif H. **Lokvam**, Kenosha, and Dr. James C. **Fox**, La Crosse, associate state chairmen.

Members of Congress



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GERIATRICS SOCIETY ESSAY CONTEST

"Relationship of Geriatric Institutions to Community Life" is the topic selected for the second annual essay contest sponsored by the National Geriatrics Society. Winners of six cash awards ranging from $500 to $100 will be announced at the 10th annual convention of the Society to be held in New Orleans, La., May 6 through 9, 1963.

Entry deadline is March 15, 1963. Identification numbers for entries, which are to be judged anonymously, may be obtained from Joseph B. Enos, M.D., president, National Geriatrics Society, 38650 Mission Blvd., Niles, Calif.

Declining Immunization Level Against Smallpox Prompts AMA Campaign for Continuing Program

America's protection against smallpox has reached a "dangerous low," the American Medical Association has warned, and beginning this month it will initiate a continuing campaign to implement an immunization program.

A statement adopted by the House of Delegates at the association's clinical meeting in Los Angeles Nov. 28, 1962, urged "physicians and their patients, particularly those who may be in contact with carriers, to maintain the needed protection against smallpox." The statement continued:

"Maintenance of protection against this serious epidemic disease requires revaccination at five-year intervals.

"A growing amount of international travel, at increasing speeds, to and from areas of the world in which smallpox is prevalent, persistently threatens to introduce the disease into the United States. Recent outbreaks in other Western nations emphasize the need for attention to this problem.

"In implementing this proven phase of preventive medicine, the American Medical Association solicits the cooperation of other health organizations and agencies."

Since no emergency exists, no "mass" or "community" programs for immunizing the population against smallpox are warranted or recommended. The AMA will direct its long-term effort toward encouraging physicians to vaccinate or revaccinate their patients against smallpox, and urging the public to go to their physicians to be vaccinated or revaccinated against smallpox.

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KEY COUNTY HOSPITALS WILL BE USED FOR LOCAL REHABILITATION

To permit mental patients to be in institutions near their own home for their final convalescence and placement, selected county mental hospitals will be put to use soon as rehabilitation centers for mental patients suited for release, the state division of mental hygiene has reported.

Although details have not yet been completed, several local hospitals have agreed to collaborate in the experiment that may be extended to other hospitals if the results achieved from the trial warrant it.

WPS INCOME AND RESERVES INCREASE

An increase in reserves of $69,547 in the month of October, 1962, raised the total reserves of Wisconsin Physicians Service, the health insurance division of the State Medical Society, to $2,266,690 as of October 31, 1962.

Premium income for the 10-month period ending October 31, 1962, was $9,013,834 as compared to $8,031,221 for the same period the previous year.

Surgical-medical insurance premiums for the first 10 months of 1962 were $4,881,911 as compared to $4,290,538 for the first 10 months of 1961. Hospital insurance premiums for the same period were $4,131,923 for 1962 as compared to $3,740,683 for 1961.

ACCP Sponsors Contest

The Council on Undergraduate Medical Education of the American College of Chest Physicians offers three cash awards annually for the best essays prepared by undergraduate medical students on any phase of the diagnosis and/or treatment of chest diseases (heart or lungs).

First prize will be $500; second prize will be $300; and third prize, $200.

Entry deadline is April 1, 1963. The official application form and details of the contest may be secured by writing Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 E. Chestnut Street, Chicago 11, Ill.

the Wisconsin Medical Journal

FEBRUARY 1963

VOLUME 62

NUMBER 2

The Heart in Sarcoidosis

Hutchinson-Boeck Granulomatosis

By WILLIAM S. MIDDLETON, M. D.
Washington, D. C.

SARCOIDOSIS (Hutchinson–Boeck granulomatosis)[1] came to increased medical attention through the experience of the Armed Forces in World War II. While its etiology remained an enigma, its relatively benign course led to certain oversights and misconceptions. Among these errors were the overemphasis on complicating tuberculosis and the minimization of the cardiac involvement in sarcoidosis.

In 1935, Salvesen[2] observed a patient with bundle branch block from independent myocardial involvement in sarcoidosis. Longcope and Fisher[3] extended this experience in reporting 6 instances of cardiac involvement in 31 sarcoid subjects. The scattered literature on the subject has been well analyzed by Peacock, Lippschutz and Lukas,[4] and Kirchheiner.[5] The latter collected 40 cases from the literature. Of this group (40), 13 were symptom-free, although the myocardial lesions were widespread in 6. Of the remainder, 23 experienced symptoms and signs of varying severity. Cardiac insufficiency was manifest in 10. Seven of this number died suddenly. Kirchheiner emphasized the prominence of atrioventricular heart block among reported patients with myocardial sarcoidosis, a circumstance that has been observed by Peacock and his associates,[4] Porter[6] and Phinney,[7] among others. In a further analysis of the fatalities from sarcoidosis, Leitner[8] collected 72 instances in the literature. Of these, cardiac failure headed the list with 26 deaths. Twelve were attributed to complicating tuberculosis. Central nervous system involvement and diverse secondary infections each were responsible for 9 deaths.

Two personal encounters with patients suffering from myocardial sarcoidosis are reported.

CASE REPORTS

Case 1: A 34-year-old negro man was admitted to the hospital complaining of cough, orthopnea, paroxymal nocturnal dyspnea and night sweats. Twelve years previously when studied for the explanation of shortness of breath and cough, sarcoidosis had been suggested as their possible basis. Nine years after this study (three years before the present admission) masses appeared on the wrists.

From the Department of Medicine and Surgery, Veterans Administration, Washington, D. C.
Doctor Middleton is Chief Medical Director of the Department of Medicine and Surgery, Veterans Administration, Washington, D. C. He also is Dean Emeritus of the University of Wisconsin Medical School.

Diagnosis

Biopsy of the removed tissue from this site fixed the histologic diagnosis of sarcoidosis. In the light of subsequent developments, the record of a normal heart at that time is noteworthy. The following year surgery was performed for a perforated peptic ulcer. A year later, the patient experienced severe abdominal discomfort and exacerbation of pain in the nodules on the wrists. Although there were no cardiovascular symptoms, an x-ray film of the thorax disclosed cardiac enlargement and the electrocardiogram showed complete atrioventricular dissociation. The progression of symptoms and signs of congestive failure, in spite of appropriate therapy, led to repeated hospitalization.

On the terminal admission, the patient complained of severe nocturnal cough and orthopnea. Night sweats and hemoptysis had been recent developments. Edema of the legs was troublesome. The physical findings, pertinent to the basic condition, included a pulse rate of 60, apical rate 60 with showers of ectopic beats, shallow abdominal respirations, decreased breath sounds, maximal cardiac impulse 11 cm. to the left of the midsternal line in the sixth interspace, cardiac enlargement to the left, splitting of the first and second sounds, healed scar in right upper quadrant of the abdomen, liver edge palpable 7 cm. below the right costal margin, three 2 x 2 cm. and one 3 x 4 cm. nontender masses, fairly firm and nonmovable, over the left wrist and pitting edema of the ankles.

The significant laboratory findings were: Prothrombin time 17 seconds, total serum proteins 7.6 gm./100 ml. (albumin 4 gm.; globulin 3.6 gm.), bromsulfalein 23%, thymol turbidity 24.6 units, calcium 10.6 mg./100 ml. X-ray film of the thorax disclosed cardiac enlargement, hilum lymph node increase and fine nodularity through both lung fields. The electrocardiogram showed complete atrioventricular dissociation with an idioventricular pacemaker and occasional multifocal ventricular premature contractions. The upper gastrointestinal x-ray studies disclosed marked deformity of the duodenal bulb without a crater.

Death from congestive heart failure on the basis of myocardial sarcoidosis succeeded six weeks of symptomatic treatment with a limited trial of steroids.

Autopsy Findings

To necropsy the following significant findings were reported by Dr. W. A. Morningstar: Pretibial and ankle edema; mass on dorsum of left wrist; enlarged inguinal and left axillary lymph nodes; apical pleural adhesions; fine granular, brownish-gray foci on pleura, pericardium and peritoneum; heart 500 gm.; epicardium, endocardium and myocardium studded with firm, confluent, minute grayish-tan nodules replacing the reddish-brown myocardium in large portions of the right ventricle and the interventricular septum; stiffening of the atrial myocardium by a pale tan, firm tissue; isolated 1 cm. smooth, irregular reddish-gray plaque-like nodule in the right ventricle subjacent to the base of the left leaflet of the pulmonic valve; endocardial involvement extending to the valves without inherent thickening; semitransparent, firm grayish-tan tissue surrounding all great vessels close to the heart; invasion of the intima of the pulmonary artery and inferior vena cava by minute, pale gray foci; extensive infiltration of the lungs by small, ill-defined, perivascular nodules (up to 0.2 cm. in greatest diameter); pleural invasion in like manner; spleen 200 gm., yellow perisplenitic plaques 6 cm. in greatest diameter and up to 0.9 cm. in thickness; tracheobronchial and periaortic lymph nodes grossly enlarged with cut surfaces mottled pale brownish-tan and black pigment; liver 1,675 gm.; perihepatitic plaques, cut surface infiltrated by firm, finely granular tan granules; elsewhere a confluent pattern of large, pale gray, irregular pseudolobules, 0.5 to 1 cm., separated by retracted arborizing dark red bloody bands; renal cortices stippled with minute depressed red dots in addition to isolated yellow cortical lesions (up to 1 cm. in diameter).

Histologic studies disclosed the essential lesions to be granulomatous in different stages of evolution. In the main they consisted of fairly circumscribed nodules of pale, polyhedral cells with single, large vesicular nuclei. Langhans and foreign body giant cells were common. Some of these contained 10 to 15 nuclei. In the lung fibrosis predominated and only a suggestion of nodularity remained. The myocardium partook of the general process. In many areas the myocardial fibres were widely separated by the granulomata and their fibrous

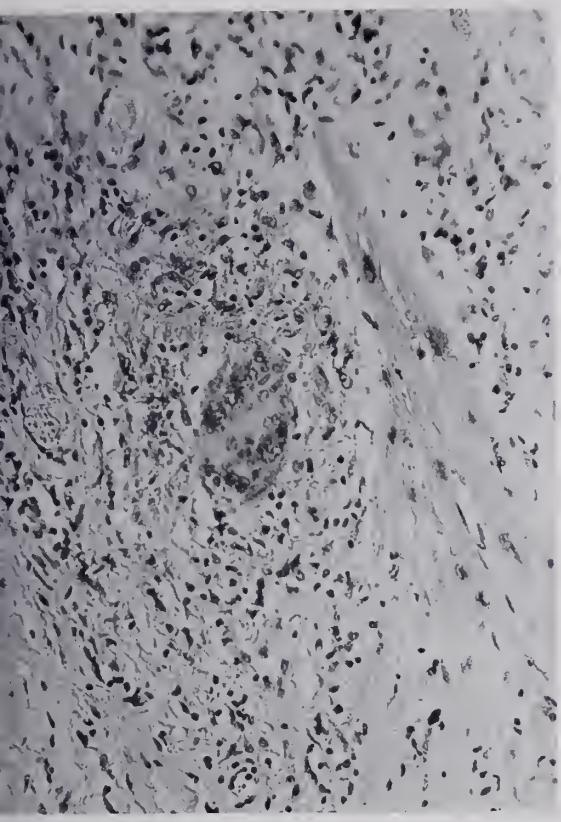

Fig. 1—Photomicrograph of myocardium (mag. x200) Case 1

tissue replacement (Fig. 1). Necrotic centers marked many of these myocardial lesions.

Discussion

The basic clinical diagnosis of sarcoidosis was confirmed. Involved in this process were the pericardium, myocardium and endocardium. The strategic position of the pathologic infiltrates explained the atrioventricular dissociation. The degree of pulmonary infiltration and fibrosis might well have led to independent cardiac embarrassment through pulmonary hypertension with right ventricular strain and overstrain (chronic cor pulmonale). Incidental sarcoidosis of the spleen, lymph nodes, bone marrow, gastrointestinal tract, liver, and kidney added to the complexity of the situation.

Case 2: A 25-year-old negro man was admitted to the hospital complaining of palpitation of three weeks' duration. There had been no antecedent illness. Milk had been prescribed for abdominal distress at the onset and after a week this discomfort was controlled. In addition to the tachycardia, a feeling of nervousness, orthopnea and nocturnal dyspnea appeared. Swelling of the ankles was observed for three or four days. Quinidine had been helpful in controlling the tachycardia at one stage. The abdominal discomfort was gnawing in nature and was aggravated by eating fried or greasy foods. As a rule, however, it appeared several hours after meals and was relieved by food. After the subsidence of the abdominal symptoms, he experienced weakness, nervousness and free sweating.

Upon physical examination the following significant findings were established: Pulse rate 160, apical rate 180, shortness of breath, pallor of conjunctivae, heart enlarged on the left side, gallop rhythm, pulmonic second sound equals aortic second sound, liver below right costal margin, edema over sacrum and ankles.

The important laboratory returns included: Hemoglobin level of 12.5 gm. per 100 ml., hematocrit reading 42 per cent, ova of Necator americanus in stools, basal metabolic rate 9 per cent plus, protein bound iodine 6.3 mg. per 100 ml. X-ray film of the thorax disclosed marked cardiac enlargement with irregular pulmonary infiltration at both bases. Subsequent studies showed clearing of basal density on the right; but the hilum increase persisted. The duodenal bulb was somewhat spastic but no niche was visualized. No hiatal hernia could be demonstrated.

Salicylates were given to control the fever (101 F.). Since electrocardiography established the tachycardia to be of ventricular origin, quinidine (0.4 gm. every two hours) was given with excellent results. The continuing congestive failure led to digitalization (digitoxin). With the recurrence of tachycardia the dosage of quinidine that had been reduced, was increased with a favorable response. The failure to establish the etiologic background for the obvious myocardial damage in this patient led to the empiric trial of 200 mg. of hydrocortisone (Cortef) daily for a week and a gradual reduction thereafter to a maintenance level of 40 mg. a day. Two months after admission the patient reported a tender area in the right lower quadrant of the abdomen.

Examination disclosed an inflammatory mass which was interpreted as an appendiceal abscess that had developed insidiously under steroid therapy. Treated conservatively with antimicrobial agents after the withdrawal of steroids, the acute abdominal process subsided without untoward symptoms. However, subsequent to this episode the right leaf of the diaphragm remained elevated to physical examination and x-ray. A thrombosis of the right external cervical vein occurred at this time. Gradually over the next four months the tachycardia became less responsive to quinidine. Cardiac failure supervened. Procaine amide hydrochloride (Pronestyl) was substituted with initial success. However, four days later the patient developed a sudden right-sided hemiplegia with aphasia. The hemoglobin level fell to 8 gm. per 100 ml. but responded promptly to a single transfusion and oral iron. A subsequent febrile reaction was attributed to the ill-defined abdominal inflammatory episode, and under renewed antimicrobial agents the fever subsided. The deterioration from this time was rapid. Seven months after admission the patient died in cardiac failure.

Diagnosis

From a clinical standpoint, the abdominal situation was ill defined. An appendiceal abscess or a perforated peptic ulcer was deemed probable with localization in a subphrenic abscess. In either event, the classical evidences of peritonitis were masked by the steroid therapy. Moreover, the condition of the patient denied surgical intervention. The etiology of the myocardial involvement was the subject of much study, including biopsy of the skeletal muscle, blood cultures, lupus erythematosus preparation of the blood and blood chemical determinations, without directional findings. Among the considerations were rheumatic fever, lupus erythematosus disseminatus, diffuse collagen disease (as polyarteritis nodosa), amyloidosis and Fiedler's myocarditis. Sarcoidosis, although cited, was given little weight.

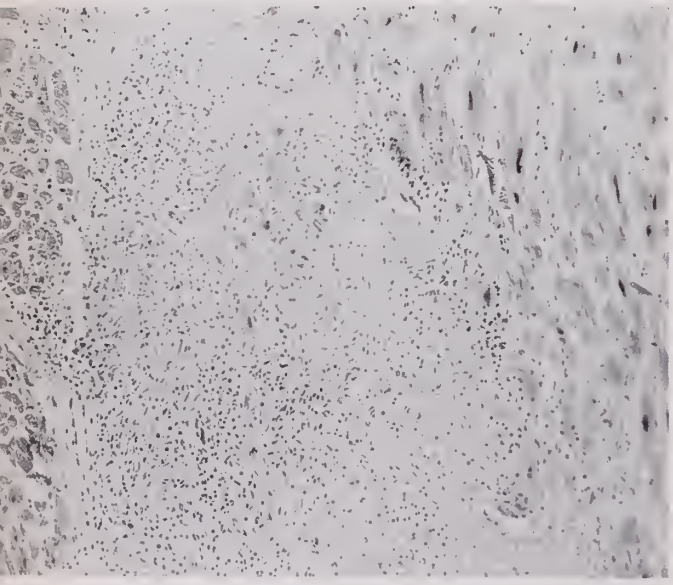

Fig. 2—Photomicragraph of myocardium (mag. x200) Case 2

Autopsy Findings

At the necropsy performed by Dr. B. E. Stanfield, the following pertinent details were disclosed: 500 ml. of slightly cloudy yellow fluid in the right pleural cavity with some fine fibrous synechiae anteriorly; 150 ml. straw-colored fluid in left pleural cavity; 150 ml. of similar fluid in peritoneal space and a like amount of clear fluid loculated laterally to the cecum; minute translucent plaques in epicardium with softening and bulging of the subjacent myocardium of the left ventricle; thickening of the right ventricular and auricular musculature; endocardium beneath the area of involvement of the left ventricle, opaque and thickened; edema of the hilum lymph nodes and mediastinum; passive congestion and infarction of the lungs; spleen 250 gm., firm, with congestion and prominence of the follicles; liver 2,300 gm., congested with accentuated central lobular markings; subdiaphragmatic abscess 10 cm. in diameter with a dense fibrotic wall; congestion of the kidneys; softening of the cerebrum in the areas of the left internal capsule and claustrium.

To microscopy the details relating to the present consideration were reported as follows: General interstitial edema of the myocardium, a fibrosing granulomatous process with destruction and separation of muscle fibres by epithelioid tubercles, giant and lymphoid cells, fibrosis marked in certain granulomata (Fig. 2), (no tubercle bacilli nor fungi defined by special stains); similar but scant tubercles in lungs, liver and lymph nodes; widespread chronic passive congestion. Encephalomalacia and sub-

phrenic and hepatic abscess, origin undetermined, completed the histologic returns.

Discussion

Although the explanation of these latter two conditions lacks definition, the basic pathologic diagnosis of sarcoidosis is sustained. Its unusual preponderance in the myocardium is noteworthy and explains the obscure cardiac manifestations of the clinical course.

SUMMARY

Cardiac involvement in sarcoidosis is stressed. Accumulating evidence gives this complication the major role in the mortality from an ordinarily benign affection. The more common manner of cardiac embarrassment is indirect through pulmonary fibrosis with eventual chronic cor pulmonale (failure of the right side of the heart). The less common manner of involvement is myocardial sarcoidosis. Indeed, it should be suspected whenever tachycardia or arrhythmia attends the course of recognized sarcoidosis. In the two patients reported, direct myocardial invasion by sarcoidosis had resulted in atrioventricular dissociation and severe tachycardia, respectively.

ACKNOWLEDGMENT: These patients were seen in conferences at the Cleveland, Ohio, and Fayetteville, North Carolina, Veterans Administration Hospitals. To Dr. Norman P. Shumway and Dr. Roger A. Jackson, and their staffs, my grateful appreciation is extended for the records of these patients.

Veterans Administration.

REFERENCES

1. Middleton, W. S.: Riddle of sarcoidosis (Hutchinson–Boeck granulomatosis). Ann. Int. Med. 41:465–478 (Sept) 1954.
2. Salvesen, H. A.: Sarcoid of Boeck, disease of importance to internal medicine. Report on 4 cases, Acta Med. Scandinav. 86:127–151, 1935.
3. Longcope, W. T., and Fisher, A. M.: Effect of Schaumann's disease upon the heart and its mechanism, Acta Med. Scandinav. 108:529–542, 1941.
4. Peacock, R. A., Lippschutz, E. J., and Lukas, A.: Myocardial sarcoidosis, Circulation 16:67–71 (July) 1957.
5. Kirchheiner, B.: Sarcoidosis cordis, Acta Med. Scandinav. 168:223–234, 1960.
6. Porter, G. H.. Sarcoid heart disease, New England J. Med. 263:1350–1357 (Dec 29) 1960.
7. Phinney, A. O.: Sarcoid of the myocardial septum with complete heart block; Report of 2 cases, Am. Heart J. 62:270–276 (Aug) 1961.
8. Leitner, S. J.: Der Morbus Besnier–Boeck–Schaumann. chronische epithelioidzellige Retikuloendotheliose oder Granulomatose. 2nd Ed., Schwabe, Basel, 1949.

TRICHINOSIS—A CONTINUING PUBLIC HEALTH PROBLEM

The diagnosis of infection with *Trichinella spiralis* has been made on a Wisconsin graduate student not only on the basis of the clinical illness but also by the demonstration of Trichina both in the muscle tissue of the patient and in the infected pork chop.

About October 1, 1962 two graduate students who shared cooking facilities, purchased two thick pork chops at a very reputable local market. Hasty preparation resulted in inadequate cooking of the chops which both men sampled. The remains of both chops were refrigerated until the next day when one student ate one chop for lunch.

About three weeks later he noted anorexia, nausea without vomiting or diarrhea followed by severe, aching muscle pains in chest and back, nonproductive cough, malaise, fever and chills. Temperature rose to 103 degrees, and eyelids became swollen. He developed severe throbbing headaches and boring eye pain. A week following onset of illness he was admitted to a hospital on November 3 with all symptoms increased in severity.

The febrile illness involving swelling of the eyelids together with history of consuming raw pork suggested the need for a Trichinella Skin Test. It was positive. Other physical and laboratory studies were negative. On November 14 a biopsy of the gastrocnemius muscle revealed *T. spiralis* with an eosinophilic infiltrate around the muscles. The patient was discharged November 17.

After discharge the patient then brought the remaining pork chop which had been kept in the refrigerator one and one-half months to the State Laboratory of Hygiene. Perhaps only a graduate student, faced with his traditional financial struggle, could provide the rare opportunity for us to examine one and one-half months later the partially consumed pork chop containing irrefutable evidence of his source of infection with *Trichinella spiralis*. Microscopic examination of the chop revealed encysted *Trichinella spiralis* in the meat, thereby clearly establishing the source of the infection. It is of interest to note the second student, not hospitalized, had milder symptoms, and an equivocally positive skin test.

This incident is reported to call attention to a public health problem which merits occasional mention to alert the public of a continuing hazard in eating improperly cooked pork.—LABORATORY NEWSLETTER, Vol. 1, No. 5, December 1962, State Laboratory of Hygiene, Madison, Wis.

EXPECTATIONS—

Great and Otherwise

By C. KNIGHT ALDRICH, M. D.

Chicago, Illinois

ONE OF THE MOST useful contributions to the understanding of adolescents in recent years has been Erikson's concept of the "identity crisis."[1] Erikson says that in order to be ready for the tasks of adulthood, an individual at the end of adolescence must have achieved a firm sense of self- or ego-identity by means of a synthesis of identifications or part identifications from his earlier pre-adult experience. Erikson speaks of a "psychosocial moratorium" between childhood and the achievement of identity as an adult which corresponds to the latency period in the psychosexual field. Failure to achieve ego-identity, or "identity diffusion," may result if the process of maturation is pushed too hard or too rapidly, or if it is unduly delayed. When the child is particularly hostile to those who make up his earlier identifications, he may develop a negative identity out of all the identifications that in the past have been considered undesirable or dangerous. Still another adolescent may merge his identification with an older individual without developing an essentially personal identity.

It would be a mistake, however, to consider adolescent identity formation and behavior solely in the perspective of past relationships and experience. The expectations of significant people in the adolescent's current environment also play a part in determining his identity as well as his behavior. The parents, the peer group, and the community all signal their expectations of success or failure in the development of identity. Expectations of failure may result from the competition within the family and the family's resentment of the child's growth. Unrealistic expectations of success frequently arise out of parental hopes for vicarious gratification through the child. Inconsistent parental expectations may result in confusion and in blocking on the part of the adolescent and the development of identity diffusion.

Some parents expect the adolescent to continue to be dependent on the parent, often in order to give the parent the indirect kind of dependent gratification which comes from having someone else dependent upon him. Although the child may give a superficial appearance of autonomy by opposing the obvious demands of the parent, he soon reveals his underlying dependent self-concept. For example, when I talked with Sally, a 13-year-old girl whose parents complained of her oppositional behavior, she insisted on her right to make her own decisions. I did not argue with her, but near the end of the interview, I wanted to know whether she would like to return. She apprehensively asked me what did I think? I said I was sincerely interested in knowing how she felt about it and that either way was really all right with me, but she was completely unable to make up her mind. I then wondered if there were times when she found it less difficult to exercise the "right" that she had just been insisting so vigorously was hers, and she said only with her mother.

How did she account for this? Well, mother always expects her to think as she does. When they go to the store, and the clerk brings out a dress, mother never asks her for her opinion first, but says, "Sally won't like this," or "Sally will like this." What irritates Sally is that mother always turns out to be right, and Sally must either follow along or oppose mother to her own detriment by refusing a dress she really likes just because mother likes it. Mother never has let her make a choice on her own, and so whenever she does not have mother to tell her what she should think, she cannot make up her mind.

Instead of expecting continuing dependency, some parents expect premature independence. The child who is expected to be independent before he is ready feels anxious and apprehensive at having so much responsibility so that he too may not be able

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Presented at the annual meeting of the Wisconsin Psychiatric Association, Three Lakes, March 3, 1962.

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to make up his mind. Sometimes both expectations are present, as when a parent expects the adolescent to be independent in money matters, but to continue to be dependent in making other decisions. Mary's father, for example, is a vigorous, outspoken, self-made individual whose theme song to his children is, "You should be independent"—provided that they are independent in his way—and who believes that religion is a disguise for dependency. Mary's independent decision to join a church at 14, therefore, met with strong objection and the criticism that she was looking for a childlike solution to her problems. Father successfully sabotaged her relationship with the church; with this failure she abandoned her attempts at autonomy. When referred at 18 she was performing poorly in school, and had no goals for herself and no idea of the kind of person she was or wished to be.

Evidence of the influence of parental expectations in determining educational and vocational choices is extensive. Learning blocks, for example, occasionally show up as defenses against forced choices. Mary's father, who insisted that she be so independent, enjoys his work as an attorney and expects his children to follow his example. Mary's brother, although he is intelligent and in other areas had a good academic record, was completely unsuccessful in his law studies. In other children, the learning blocks are more generalized. Not every parent who wants his son to follow his own profession will produce a learning block, particularly if the child really does have a choice.

Some parents expect the child vicariously to accomplish for them or successfully to compete for them. William has a self-made dominating father who is successful in business but who never had much of an education. His father is determined that William should have a college education. William, with a reasonable degree of logic, points out that father has done pretty well without one, but father brushes his objections aside, saying that "things are different now." William opposes father out of his need to develop a separate identity; if he goes to college, he would simply be an agent for father to obtain a vicarious college experience. Incidentally, while all this is going on, William also responds to another signal, a signal to which father apparently is not alert. Instead of studying, William works with father's ne'er-do-well brother who spends all his time and all his money in racing stock cars. An interview with father soon reveals that, although overtly angry, father is covertly envious of his brother, and that father's own strong but unacceptable impulse to enjoy automobile racing is being acted out for him by his son. William thus identifies with the part of his father's personality that father cannot accept and avoids identification with the part that father accepts.

Ernie is a good example of a reaction to parental expectations of failure. Ernie's father cannot tolerate competition, so he looks for failure in his son, and undercuts any success that Ernie has. Ernie, who is no longer an adolescent, has done well in two or three professional efforts, and consciously sees his accomplishments as proof that father is wrong. However, success really never means anything to him. Once he achieves a beginning success, he finds there is something lacking—he is never quite convinced that his success is genuine—so he abandons the attempt and starts out on another tack and another attempt to prove father wrong.

Bob's mother is convinced that Bob is going to fail, partly in support of her attempt to prove that men are inferior, and partly because Bob is a scapegoat for some of mother's impulses to be a nonconformist. She expects Bob not to study; Bob, apparently in response to her expectation, secretes a mystery story inside of his mathematics or Latin book and opens his desk drawer. Then, as he hears mother tiptoeing upstairs to check on him, he slips the mystery story in the drawer. Consciously, he is outwitting his mother, but actually he is satisfying her expectation of his failure. When I pointed this out to Bob, he said he could not understand why his mother was so stupid; the third stair from the top squeaked loudly so that he always heard her coming and had time to hide the book. He could not understand why she did not skip that step.

We finally decided that the squeaky step served to maintain the status quo. So long as she gave the signal, she did not have to come to grips with his failure to study, but the fact that she kept up the ritual strongly suggested that she knew what he was doing but feared (or did not wish) to do anything to stop it. After we had discussed the lack of

gratification in playing a game in which one always won, Bob began to realize that he was defeating himself whenever he outwitted his mother. (I did not point out that his failure may have represented his mother's real goal.)

Parental expectations also may interfere with the development of the adolescent's social identification and sexual role as a male or female. The parent who expects the child to replace the other parent is often a seductive mother who expects her son to replace a dead, divorced, inadequate, alcoholic or passive father. The child's fear of the consequences of success commonly leads to the fear of maleness. Somewhat less evident is the parent's expectation that the child will protect the parent against his own seductiveness. The father who is attracted by his adolescent daughter but expects her to set the limits to his impulses frightens her and makes it difficult for her to accept her femininity.

Another common expectation is that the child will in some way compensate a parent for being a girl when a boy was desired or vice versa. The girl who is a tomboy tries to make up to her father for his failure to have a son. She may be reasonably successful until adolescence, when father retreats as he begins to sense that his relationship with his tomboy daughter no longer has the same implications that it had before she became adolescent. Her identity crisis is intensified by her rejection of femininity (or fear of femininity, when the tomboy role represents more of a defense against the sexual component of the relationship with father), and by her inability to continue to sustain the pseudo-masculine role.

Parental expectation is a crucial factor in the development of sexual deviations. Walter, a practicing homosexual, recalled that from early childhood, his father had expected him to be a sissy and had worked overtime to force him into activities which would counteract his expectations. Thus Walter was pushed into boxing when he was too young and not well equipped for it, and prematurely into other kinds of highly masculine activities in which he failed. His failure increased his father's anxiety and his efforts to force Walter into masculinity, until eventually the expectation of homosexuality was rewarded with the actual development of a homosexual orientation. *

All expectations of sexual deviation do not result in sexual deviation. Some adolescents successfully and even dramatically resist the pressure. Florence's mother wanted to know what could be done about Florence who had a crush on a girl friend. The two friends, each 11 years old, spent hours locked in the bedroom, excluding mother who assumed, solely from the giggling and whispering, that physical homosexual activity was going on. As far as I could tell, the evidence was primarily in her fantasy; she was convinced that she was right, however, and undertook a campaign for the next four years, with indifferent success, to keep her daughter and friend apart. After four years Florence finally was able to convince her mother that she was not homosexual by becoming pregnant out of wedlock.

The case of Florence leads directly into the general area of the development of a moral code and of controls, on which Johnson and Szurek[3] have written extensively. Parental expectation that the child will act on his impulses communicates to the child their lack of confidence that the child can exert controls over his impulses, and if the parents do not have confidence, the child can only believe that he is powerless. The child then behaves, or misbehaves, as expected. This self-fulfilling prophesy is frequent in sexual areas. We seldom see an unmarried mother in adolescence, or, as a matter of fact, in any other age group in which it is not clear that the parents expected the child to act out sexually. The typical story is that the child has always been told that she must come home from dates at a stated hour, and if she is not home at that hour, it is implied that she must be misbehaving. The stated reason usually is that she needs her rest. But after she gets home, mother gives her the third degree to find out exactly where she has been and what she has been doing. Since the inquisition takes an hour or so, it is evident to the child that it is not her rest that her mother is so concerned about.

The expectations of parents, as well as of peers and the community, affect delinquent behavior in other than sexual areas. I saw Chris after he had stolen a car. The parents

* In this paper I am primarily concerned with the fact of the expectation and not with the reason for the expectation. For a full discussion of the genesis of sexual deviations, see Johnson and Robinson's "The Sexual Deviant (Sexual Psychopath)—Causes, Treatment and Prevention."[2]

were upstanding members of the community who could not understand what made it possible for him to steal. Although we thought at first that his self-righteous father was expecting Chris to express some unacceptable impulses of his own, it became evident that it was mother who initially had expected Chris to steal. It all started in a conflict between Chris' normal adolescent appetite and mother's rigid ideas about eating between meals; this conflict developed into quite a game between the two, with mother hiding or locking up potato chips and other snacks, and Chris finding them and picking the lock. This interaction was not a game to mother, however, who saw it as proof that Chris was and would be a thief. If he stole cookies and potato chips, he would steal cars or anything else. He accepted her expectations that he would be powerless to resist the temptation if an opportunity to steal appeared, and so when he found an unattended sports car with a key in the lock, nothing kept him from driving off in it.

Parental expectations of adolescent misbehavior are stimulated by the devaluation of parental authority which is part and parcel of adolescent growing up. As the adolescent begins to flout the parental standards of manners, as he wears beat-up shoes and blue jeans when his parents think he ought to be dressed up, as he uses peculiar language and pays more attention to crooners than to teachers, the parents, confusing the rebellion in manners for a rebellion in morals, are stimulated to expect the worst.

The parents are not the only participants in developing an atmosphere in which antisocial behavior is expected. In slum environments, where the incidence of delinquent behavior is high, the expectations of delinquency by society, the community and the peer group are greater. The higher the incidence of delinquent behavior in a neighborhood or in a racial group, the more reason there is for both parents and the community to expect delinquent behavior. But even in so-called good neighborhoods, the community expects some adolescent delinquent behavior. In any given case, the family and cultural factors should be examined, and both the sanctions for the expression of antisocial behavior and the defenses against their expression should be assessed.

Whoever treats an adolescent successfully must help the patient expect more of himself than others have expected. The therapist must expect the adolescent to behave consistently with society, to develop a reasonable degree of independence, to make educational and vocational choices within his competence and his interests, and to develop an identification as a male or female. Successful treatment requires optimistic expectations on the part of the therapist. The therapist must not reinforce the expectations of failure or deviation which the parents and peer group and the community have signaled to the child. The communication of optimistic expectations is hampered if the therapist concentrates exclusively on symptomatology and on unresolved conflicts rather than on personality strengths. Empty reassurance which is not based on understanding of the individual is valueless, but in the treatment of the adolescent it is even more important than in the treatment of adults to recognize and to support the strengths and the healthy defenses that the patient demonstrates. Optimistic expectations are more difficult but by the same token more necessary after than before delinquent or deviant or self-defeating behavior.

The adolescent patient's family may be able to support his growth and the development of his identity. Family members are the best potential treatment resources and should be enlisted as allies whenever feasible by emphasizing from the outset their current interest and concern for their child rather than by criticizing their past child-rearing attitudes. On the other hand, continuing conscious or unconscious family expectations of failure, of delinquency, of deviation and so on may seriously interfere with treatment. The peer group and the community may affect treatment in the same way, although it is more difficult to work with them than to work with the parents. Johnson and Szurek[3] believe that unless the "significant" parent is in treatment, it is not worthwhile trying to treat a delinquent who lives at home. In general I would agree, although I think that sometimes the adolescent who is beginning to emancipate himself from his parents can begin to catch the signals that are being given by the parent, and then can avoid responding to them even if the parent is not in treatment. For the most part, though, it is best through treatment to help the parents modify their

expectations. Sometimes the only alternative is removal of the adolescent from the family, either through hospitalization, foster home care or other resources. Some therapists concentrate exclusively on the parents, which may prove adequate provided that the adolescent is not deprived of a relationship, support, or sounding board that he may need to help him in .the solution of his problems.

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REFERENCES

1. Erikson, E. H.: Problem of ego identity in Stern, M., Vidich, A. J., and White, D. M.: Identity and Anxiety, Glencoe, The Free Press, 1960, pp. 37–87.
Also Erikson, E. H.: Youth: fidelity and diversity, Daedalus 91:5–27 (Winter) 1962.
2. Johnson, A. M., and Robinson, D. B.: The sexual deviant (sexual psychopath)—causes, treatment and prevention, J. A. M. A. 164:1559–1565 (Aug 3) 1957.
3. Johnson, A. M., and Szurek, S. A.: Etiology of antisocial behavior in delinquents and psychopaths, J. A. M. A. 154:814–818 (Mar 6) 1954.

See also:

Freud, A.: Adolescence in the Psychoanalytic Study of the Child, New York, International Universities Press, 1958, Vol. 13, p. 275.

Lorand, S., and Schneer, H. I., Eds.: Adolescents: Psychoanalytic Approach to Problems and Therapy, New York, Paul B. Hoeber, Inc., 1961.

Bettelheim, B.: Problem of generations, Daedalus 91: 68–96 (Winter) 1962.

Gardner, G. E.: Psychiatric problems of adolescence in Arieti, S., Ed.: American Handbook of Psychiatry, New York, Basic Books, 1959, pp. 870–892.

TULAREMIA IN WISCONSIN

Miss Jean Koehler of Immunology and Dr. Wayne Thompson of the Zoonoses Research Unit reported the following data regarding serologic and epidemiological investigation of several recent outbreaks of tularemia in Wisconsin:

Near Woodruff, a mink rancher and his helper were hospitalized with tularemia during March. The owner of the ranch found a lesion on the dorsum of his fourth finger. He had a temperature of 103 F., with lymphangitis and adenitis. Serum tests were negative eight days after the first symptoms, but agglutinins to tularemia developed to a titer of 1280 at 29 days, and to 2560 at 35 days.

Three weeks later his helper was also hospitalized with a large lesion on the left thumb and tenderness and swelling in the axillary nodes. His serum had a titer of 160 to tularemia at 5 days and 5120 at 17 days. Both patients recovered after treatment with streptomycin by their physician. Two other workers on the mink ranch did not develop clinical symptoms, and tests on their sera were negative.

Several sick mink on the ranch were examined by the Animal Diagnostic Laboratory and the Veterinary Science Department. Seven out of ten mink sera tested showed high agglutinin titers and the tularemia organism was isolated from the mink tissues by C. D. C. The most likely source of the infection was believed to be frozen jackrabbit meat which had been shipped in from Wyoming for mink food.

A seven-year-old New London boy was infected during April after helping flesh a muskrat on his father's fur farm. A lesion developed on the little finger of his left hand, which he had also previously skinned on a doorknob. He soon had a temperature of 103.8 F., with pain and enlargement in the lymph nodes in his left arm. His serum had agglutinins to tularemia of 640 at 26 days, 2560 at 44 days, 640 at 66 days, and 320 after 78 days. He made a prompt recovery after several treatments by his physician.

Tests on his father's serum showed a titer of 320, although his only history of known infection was eight years ago. The boy's 12-year-old brother's serum had a titer of 640, and serum of a part-time helper on the fur farm was 320. Neither of these two had a history of known infection, but it is likely that they had mild or subclinical infections in the past. The boy's mother had no history of infection and her serum was negative.

During June a Conservation Department beaver trapper was hospitalized in Marshfield for four days with a temperature that rose to 104 F., pain and swelling in lymph nodes, and a lesion on the little finger of his right hand. His serum had a titer of 40 at 11 days, which increased to 320 at 27 days.

During September, sera were collected from 12 muskrat fur farmers, other than those in the above cases. Three of these 12 had agglutinins, with titers of 40, 80, and 160, indicating past infections. These were all negative to brucella. According to a study of 87 tularemia cases in Baltimore (J. of Inf. Dis. 69, 3, 1941) titers started to climb after five days, averaged about 5120 at the end of a month, then gradually declined to an average of about 640 at the end of a year. Titers lasted for 10 years or more, with a gradual decline over this period of time.

In addition to groups indicated above, hunters and woodsmen are high risk groups to tularemia infection because of contacts with infected rabbits and ticks.

Appreciation was extended to the following Wisconsin physicians who made this study more complete: Dr. Josef Preizler, State Board of Health; Dr. William Hiatt, Woodruff; Dr. G. P. Dernbach, New London; Dr. Lloyd Maasch, Weyauwega; and Dr. Stanley Custer, Marshfield.—*Laboratory Newsletter*, Vol. 1, No. 3, October 1962, State Laboratory of Hygiene, Madison, Wis.

WILMS' TUMOR: Study of 29 Cases

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WILMS' TUMOR is one of the most common solid neoplasms of the first decade of life. The incidence of this disease has been quoted by various authors to be 1 in 3,000 patients in one children's hospital[1] and in other institutions 1 in 25,000.[2] Over the past five years we found the incidence in this institution to be 1 in 6,000 admissions.

This is a retrospective study of patients with Wilms' tumor, seen from 1931 through the first half of 1960, for the purpose of evaluating the method of therapy utilized and the results obtained. Features of the disease, such as age of onset, amount of time elapsed from the appearance of the first symptom to time of treatment, types of symptoms, pertinent physical findings, and the diagnostic value of urographic studies and laboratory examinations were reviewed in an effort to ascertain their influence on the course and eventual outcome of this disease.

The tumor has been known over the years by numerous names. The most commonly used terms include embryonal nephroma, malignant nephroblastoma, adenomyosarcoma, and Wilms' tumor. The common usage of the term, Wilms' tumor, came about because the generally accepted theory of the origin of various morphologic elements observed in this tumor was first proposed by Wilms. He believed that the presence of various elements, such as striated and smooth muscle, bone and rudimentary renal structures, could be explained satisfactorily by differentiation of mesodermal tissue into myotome, sclerotome, and nephrotome early in fetal life.[3] Histologically, the typical tumor contains many or all of the following tissues with one or two of these cell types usually predominating: small undifferentiated spindle cells, cuboidal epithelial cells, smooth and striated muscle fibers, adipose tissue, pseudotubuli and pseudoglomeruli, blood vessels, and occasionally cartilage and bone. Frequently, however, there is only an irregular orientation of epithelial cells resembling rudimentary acini or papillae.

Some authors have noted the association of certain congenital renal and extrarenal anomalies, such as horseshoe kidney, polycystic kidney, dextrocardia, harelip, and others. In our series, Wilms' tumor was found in one patient with horseshoe kidney and in another with congenital corneal opacities, pyramidal tract and cerebellar degeneration.

Whether the finding of tumor in both kidneys early in the course of the disease represents bilateral primary tumors or whether it is indeed metastasis from one kidney to the other is a question difficult to settle. Some doubt exists as to the actual occurrence of bilateral primary tumors since none has ever been reported in the fetus, newborn or stillborn infant. There has been, however, a total of 51 cases reported in the literature up to 1958 as representing bilateral Wilms' tumor.[4]

The clinical picture presented by this disease has been well documented in the past by numerous authors. The initial or presenting complaint of a palpable abdominal mass should immediately alert the physician to this diagnosis. Melicow,[5] in his report of 653 cases of palpable abdominal tumors in infants and children, showed that about one-third of the masses were of renal origin which included cysts and hydronephrosis in addition to Wilms' tumor. Wilms' tumor constituted approximately 30 per cent of these renal masses which were distinguishable from the extrarenal tumors in 4 of 5 cases by clinical history, physical examination, laboratory studies and urographic findings.

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Presented before the Wisconsin Radiological Society at the 121st annual meeting of the State Medical Society of Wisconsin, May 10, 1962, Milwaukee.

Doctor Hinke was an American Cancer Society Fellow in Radiology July 1, 1960 to June 30, 1961.

ACKNOWLEDGMENT: Some of the patients in this series were treated under the supervision of E. A. Pohle, M. D., Emeritus Professor of Radiology.

Epigastric, abdominal, or flank pain are quite common and may at times lead to the discovery of the mass by a parent or the physician. Hematuria, either gross or microscopic, is not a frequent occurrence. Fever, anorexia, nausea, and vomiting are often associated symptoms. Constipation is a rare complaint and diarrhea is sometimes associated. Hypertension has been observed and this is most probably on the basis of renal ischemia or perirenal inflammation. Our series showed a rather high incidence of elevated blood pressure.

Excretory urograms are most helpful, and retrograde pyelograms are necessary to clarify indeterminate findings only infrequently. In our series of cases 86 per cent of the urograms showed abnormality of the collecting system as well as the presence of a mass.

The laboratory studies are not often of value in establishing the diagnosis of Wilms' tumor of the kidney since urinary abnormalities, such as hematuria, are uncommonly present. The blood urea nitrogen is elevated only when there is urinary tract obstruction or extensive bilateral involvement. The most frequent abnormal laboratory finding is that of anemia.

Metastases occur most often in the lungs, probably because of the frequent invasion of the renal vein. The next most frequent sites of metastatic involvement in order are liver, bones, and opposite kidney. Rarely observed are metastases to the skin, brain, orbits, bladder, or colon.

Through the years the treatment method of choice has consisted of surgical removal of the tumor plus irradiation to the renal fossa. This irradiation is given either preoperatively or postoperatively, or both. Surgery alone or irradiation alone have been shown in the past to be less effective than the combination of the two.

Complications from the treatment must be kept in mind. Rupture of a huge friable adherent tumor with contamination of the peritoneal cavity may lead to implantation of tumor. Removal of very large tumors may be followed by shock or postoperative ileus. Hypertension secondary to radiation nephritis of the remaining kidney, alteration in bone growth resulting in deformities, such as scoliosis, damage to gonads, and radiation pneumonitis have been reported.[6,7,8] The majority of these complications can be avoided by careful planning and execution of the surgical and radiotherapeutic procedures.

CLINICAL MATERIAL

The records of 40 cases of patients with diagnosis of Wilms' tumor seen during the period of 1931 through 1960 were studied. Of this number, the diagnosis was confirmed histologically in 33 cases. Three of these cases have been followed only one year, and a fourth has been followed for two years. Consequently, these 4 patients have not been observed long enough to be included in determining the survival figures, and the discussion in the main will concern the 29 proved, followed cases. The other 7 patients were clinically suspected of having Wilms' tumor but no histological proof was established. There were 19 females and 10 males.

Initial Complaint: A mass noted by the child's parents was the reason for seeking medical aid in 14 of the patients. In most instances, the mass was discovered incidentally while the child was being bathed or dressed. In one case the child's teacher raised the question of abdominal mass when she noticed that the child's ribs protruded on one side. Pain was the presenting complaint leading to the discovery of a mass in 9 patients. Hematuria was the initial symptom in only 3 and fever in 2 patients (Table 1). Only in one patient was a gastrointestinal symptom, namely progressive constipation, responsible for the seeking of medical help. Fever was an accompanying symptom in 5 patients, vomiting in 4, and hematuria in 3. There was one case of bedwetting and one of urinary urgency.

Duration of Symptoms or Signs Prior to Medical Attention: The time interval from the onset of symptoms or signs until the patient was seen by a physician ranged from 1 day to 11 months with an average of 1.8 weeks. For the patients who survived at least 3 years the time interval averaged under 1 week with a range of 1 day to 3 weeks. This interval for the nonsurvivors averaged 4.5 weeks with a range of 1 day to 11 months.

Age Incidence: The ages ranged from 2 months to 9 years with 8 patients under one year (Table 2). It is of interest and apparently significant that 4 of 6 survivors were under the age of one year at the time of diagnosis and treatment. The other 2 sur-

TABLE 1—*Primary Presenting Complaints (29 proved, followed cases)*

	Number	Per Cent
Palpable abdominal mass	14	48
Abdominal pain	9	31
Hematuria	3	9.8
Fever	2	6.9
Constipation	1	3.4
Totals	29	100

TABLE 2—*Age Incidence*

Year	Number of Patients
Under 1	8
1 to 2	1
2 to 3	9
3 to 9	11
Total	29

vivors were between two and three years of age, and there were no survivors between one and two or any over three years of age. Expressed in percentages, 50 per cent of all patients under one year survived.

Physical Findings and Laboratory Studies: A palpable abdominal mass was found in 28 of the 29 proved, followed cases. In one patient where a mass was not suspected, a tumor was found subsequently upon emergency laparotomy performed because of abdominal pain and a decreased hemoglobin following a fall from a chair. The mass was smooth and firm, indicating renal origin. In other patients, left-sided masses were diagnosed originally as splenic enlargement. Our series indicated about a 2:1 predominance of left-sided involvement over right (left 20; right 9). There was one case in which the right side of a horseshoe kidney was involved.

Metastatic disease was suspected by the presence of hepatic enlargement in 2 patients. Laboratory findings generally contributed little to the establishment of the diagnosis. Only 1 definitely elevated nonprotein nitrogen was recorded. Phenolsulfonephthalein kidney function tests were done in 5 patients with only 1 of these being abnormal. Erythrocyte sedimentation rate determinations were done in 4 cases; 2 of these were elevated. Serum alkaline phosphatase studies were done in 3 cases without metastases and all 3 were normal.

Blood pressure determinations were recorded in 19 cases and in 6 of these hypertension was found (31%). In 3 of these patients the elevated pressure returned to normal, in one following preoperative irradiation only, in another after surgery alone, and in the third following surgery and postoperative irradiation. In 1 patient the pressure, which was initially normal, rose to an elevated level following x-ray therapy alone. In 3 of the patients the elevated pressures remained unchanged in spite of therapy.

Urography: Information on kidney structure by means of urography was adequate in 21 cases. In 18 of these patients excretory urography was done and definite changes were found, consisting of the presence of one or more of the following: (1) nonfunction of the kidney, (2) distortion of the collecting system, (3) displacement of the collecting system. A calcified focus in the lesion was found in only one case. In the 3 cases showing normal bilateral function a mass was apparent. Retrograde urography was resorted to only occasionally; and in one case of a nondiagnostic excretory urogram, the retrograde study showed a large kidney with deformed calyces. It would appear that excretory urography will lead to the proper diagnosis in most of the cases.

Treatment: Surgical removal was employed in all but 5 patients who were deemed inoperable at the time of admission primarily because of the presence of metastatic disease. One patient was treated with chemotherapy alone (5–FU) because of the advanced state of his disease. Three patients received x-ray therapy alone and were treated for palliation only. Actinomycin D was used in an attempt to control metastases in 7 patients. One of these received actinomycin D prophylactically along with nephrectomy and postoperative radiation.

All three-year survivors had some combination of surgery and x-ray therapy. Preoperative x-ray therapy followed by nephrectomy yielded 2 survivors out of 3 cases treated in this manner. Of 12 patients treated with surgery and postoperative therapy there were 2 survivors. Preoperative irradiation followed by nephrectomy and postoperative radiotherapy resulted in 2 survivors of 7 cases treated in this manner (Table 3).

Surgical removal in 4 of the survivors was apparently complete. However, 2 of these died from tumor 3⅓ and 6 years respectively after treatment. In the fifth pa-

TABLE 3—*Three Year Survivals According to Treatment Method*

Method	No. of Cases	No. of Survivals	Per Cent Survival by this Method
Surgery only	1	0	0
X-ray therapy only	3	0	0
Preoperative irradiation and surgery	3	2	67
Surgery and postoperative irradiation	12	2	17
Preoperative irradiation followed by surgery, followed by postoperative irradiation	7	2	28
No irradiation or surgical treatment	3*	0	0
Totals	29	6	

*Two received chemotherapy.

tient, still alive and free of tumor for 15 years, there was definite spread to local surrounding tissues and regional node involvement. In the sixth patient, alive 23 years, there was no information available as to the completeness of the removal.

The radiation doses, as well as the quality of the radiation administered, varied widely. When preoperative irradiation alone was used, the doses varied between 420 and 900 r/a, given at the rate of 100 r/a daily. The doses used in postoperative irradiation ranged from 1000 to 4000 r/a with about half of the patients receiving 1000 to 2000 r/a and one-half of them receiving 3000 to 4000 r/a. The dose rate here was usually 200 r/a daily with a quality of 1.05 mm. of Cu. HVL. When both preoperative and postoperative irradiation were administered, the preoperative doses ranged from 1050 to 3400 r/a and the postoperative doses ranged from 900 to 2500 r/a, most of them being about 1200 r/a. The half value layer also varied with this method from 0.5 mm. to 1.55 mm. Cu. One patient was treated with million volt x-rays, HVL 9 mm. Cu.

Fig. 1—Film of six-month-old girl with Wilms' tumor of left kidney treated with preoperative x-ray therapy and nephrectomy. Alive and well 15½ years after treatment.

Two of the 6 patients who survived at least three years died subsequently, one after three and one-third years from recurrence, the other six years after treatment from generalized metastases. At this time 4 patients have survived from 15 to 23 years and are without evidence of disease. The age at the onset of the disease in these 4 long-term survivors ranged from 5 to 11 months, for an average age of 8.4 months. The average age of the 6-year and 3-year survivors was 9 and 16.5 months respectively, and of those surviving less than 2 years, 3.3 years (Tables 4 and 5).

COMMENT

It is very difficult to compare survival time in this disease as reported from various sources and arrive at definite conclusions. Authors' criteria for cures and survivals differ and any one series may include a disproportionate number of patients referred for treatment and management of metastatic disease after the primary diagnosis and treatment were carried out elsewhere,

TABLE 4—*Age of Patients at Onset of Disease and Survival*

Length of Survival	Age Range	Average Age
15 year survivors	5½ to 11 months	8.4 months
6 year survivors	5½ months to 2½ years	9.0 months
3 year survivors	5½ months to 3 years	16.5 months
Less than 2 year survivors	2 months to 9 years	3.3 years

TABLE 5—*Survivals*

	Number	Per Cent of Total
Survived 3 years	6	20.5
Survived 6 years	5	17.0
Survived over 15 years	4	13.8

Fig. 2—X-ray study of two-year-old girl with Wilms' tumar of right kidney treated with nephrectomy followed by postoperative irradiation to right upper side of the abdomen. Pulmanary nadule developed an the left side immediately, treated with x-ray therapy and actinomycin D and camplete regression. Four months later a solitary pulmanary nadule developed an the right side also was treated with x-ray therapy and actinomycin D, but failed to regress. It was resected. The patient is alive and well today, 20 months after first treatment.

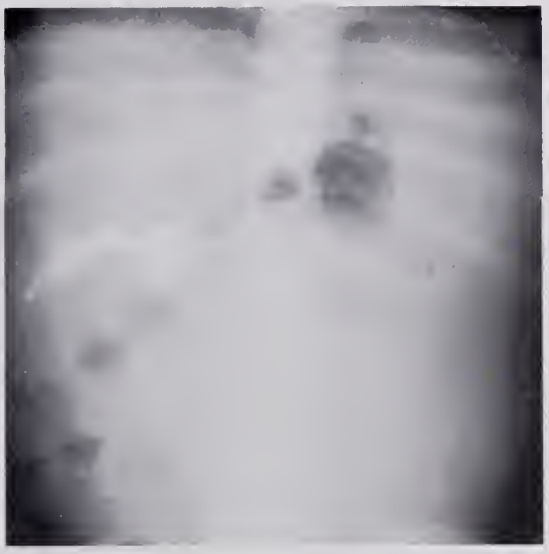

Fig. 3—X-ray film showing three-year-old boy with bilateral Wilms' tumor. The left kidney occupied by a huge Wilms' tumor was remaved after preoperative x-ray therapy. The right kidney showed a Wilms' tumor at the lawer pole which was biopsied and given 2000 r/t af x-rays. The tumor regressed but the patient died of metastases 10 months later.

as was the case in the present study. The three-year survival rate of 20.5 per cent in this series is comparable to that reported by many authors; but as these patients are followed longer, we note that the five-year survival rate drops to 17 per cent; and with still further follow-up, we arrive at an absolute survival rate of 13.8 per cent. The apparent cure rate in patients presenting without clinical evidence of metastases and receiving treatments aiming for a cure was 17 per cent (4 of 23 patients).

Some of the best survival figures have been reported by Gross and Neuhauser,[9] who obtained an overall "probable cure rate" of 47.3 per cent in patients followed from 1940 to 1947. Kinzel,[2] reporting on patients followed from 1941 through 1955, showed a three-year overall survival rate of 37.2 per cent. Klapproth,[4] in his extensive analysis of the literature, pointed out that 85 per cent of patients who succumbed died during the first postoperative year, 10 per cent during the second year, 3.3 per cent during the third year, and only 1.9 per cent died after the third year following treatment. We found 2 patients who died after the third year from metastases.

The prognosis in patients under one year of age is more favorable. Two-thirds of our survivors were in this age group and 50 per cent of all of our patients under one year of age survived at least three years after the diagnosis was made. Gross reported 80 per cent three-year survival in patients under 12 months of age, and Kinzel 67 per cent five-year survival in patients less than 2 years old at the time of the diagnosis.

As in other malignant tumors, early diagnosis is an important factor in improving the prognosis. The child with a palpable abdominal mass should undergo urographic studies and laparotomy as soon as possible. Since surgery is often difficult, especially with large tumors, because of the risk of rupturing the capsule and spillage with contamination of the peritoneal cavity, it might be well to refer such patients as emergency cases to larger medical centers.

Radiation therapy to the postoperative site is justified in all cases even though surgical removal is thought to be complete, the purpose of irradiation being to eradicate any tumor cells that could conceivably be left in the renal bed and regional lymphatics.

Adequate dose levels from 3000 to 4000 r as calculated to the tumor bed are recommended. These dosages are somewhat higher now than those given in the past, and there is reason to assume that the effectiveness of the radiation will be increased. High energy radiation has the advantage of causing less skin reaction and less bone absorption than the lower energy radiation. To prevent the complications of radiation nephritis and subsequent hypertension, the opposite kidney should be properly shielded. The field should be adjusted in order to include the entire transverse extent of the vertebral column to prevent development of scoliosis as a long-term complication of the radiation.

The accepted method of primary treatment of Wilms' tumor is a combination of nephrectomy and radiation therapy. The controversy as to whether to employ preoperative radiation followed by nephrectomy, or nephrectomy followed by postoperative radiation, or radiation both pre- and postoperatively has not yet been settled. Definite conclusions as to the relative merit of any of these methods are difficult to arrive at, but it is interesting to note that in the present series, of three cases treated with preoperative radiation and nephrectomy, there were two 15-year survivals. Klapproth,[4] in his review of 1,351 cases, demonstrated that in utilizing any of the three methods the survival rate was essentially the same, being 27.1 per cent, 26.2 per cent and 24.1 per cent respectively. Kinzel's three-year survival rates for these methods were 50.0 per cent, 23.1 per cent, and 57.1 per cent respectively. In recent years, when possible, nephrectomy, often through a thoracoabdominal incision followed by immediate postoperative radiation, has been employed. Gross prefers this method and advocates that postoperative radiation be started on the day of surgery.[9]

In the management of advanced cases with large and extensive tumors, where primary surgery is not deemed feasible, preoperative radiation of a dose of 1000 to 2000 r to the tumor is followed by surgery. This preoperative radiation alters tumor cells to the extent that they are less likely to be capable of proliferating even though they may escape into the circulation. Surgery is mandatory because complete sterilization of large primary tumors is difficult with radiation alone, probably because of the multiplicity of tumor elements with some of the cell types being more radioresistant than others. The treatment of metastatic disease involves the use of radiation therapy alone at times to a solitary lesion or recurrent masses, or x-ray therapy combined with chemotherapy. One of our patients had complete disappearance of multiple bilateral pulmonary metastases seen on chest x-ray film following only 1000 r tumor dose plus actinomycin D given intravenously. Another patient, who has received repeated courses of radiation and actinomycin D for recurrent pulmonary nodules which first appeared one year following nephrectomy, has survived two years to this date but pulmonary metastases are still present. D'Angio and Farber[10] reported six of 13 patients with pulmonary metastases from Wilms' tumor surviving two years by utilizing combined radiation and actinomycin D therapy. The use of actinomycin D as a prophylactic measure immediately following postoperative radiation may have some merit.

SUMMARY

Twenty-nine histologically proven cases of Wilms' tumor have been studied. The prognosis with surgery and radiation therapy is best in children below the age of one year. Preoperative irradiation is considered indicated in patients with large tumors. Postoperative irradiation is mandatory in all patients with Wilms' tumor. Radiation therapy in combination with actinomycin D may lead to long remissions in patients with metastases.

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REFERENCES

1. Scott, L. S.: Renal tumors in childhood, Glasgow M. J. 35:33–45, 1954.
2. Kinzel, R. C., et al.: Wilms' tumor—review of 47 cases, J. A. M. A. 174:1925–1929 (Dec 10) 1960.
3. Wilms, M.: Die Mischgeschwuelste. Heft I: Die Mischgeschwuelste der Niere, Leipzig, Verlag Arthur Georgi, 1899, pp. 1–90.
4. Klapproth, H. J.: Wilms' tumor—report of 45 cases and analysis of 1,351 cases reported in world literature from 1940 to 1958, J. Urol. 81:633–648 (May) 1959.
5. Melicow, M. M., and Uson, A. C.: Palpable abdominal masses in infants and children—report based on a review of 653 cases, J. Urol. 81:705–710 (June) 1959.
6. Whitehouse, W. M., and Lampe, I.: Osseous damage in irradiation of renal tumors in infancy and childhood, Am. J. Roentgenol. 70:721–729 (Nov) 1953.
7. Neuhauser, E. B. D., et al.: Irradiation effects of roentgen therapy on the growing spine, Radiology 59:637–650 (Nov) 1952.
8. Harvey, R. M.: Wilms' tumor—evaluation of treatment methods, Radiology 54:689–696 (May) 1950.
9. Gross, R. E., and Neuhauser, E. B. D.: Treatment of mixed tumors of kidney in childhood, Pediatrics 6:843–852 (Dec) 1950.
10. Personal communication.

ROENTGEN DIAGNOSIS of Compartmental Disease of the GALLBLADDER

By I. NIK NEVIN, M. D.,
WARNER S. BUMP, M. D.,
and IRVING E. SCHIEK, JR., M. D., Rhinelander, Wisconsin

INTEREST in the x-ray recognition of congenital malformations of the gallbladder was stimulated by classical investigation of Boyden[1] and the extensive review of the literature by Gross[2] following introduction of cholecystography by Graham and Cole.[3] The careful embryological study of Boyden[4] on the development of the phrygian cap led him to conclude correctly that the folded fundus of an otherwise normal gallbladder has no clinical significance. Else[5] properly suggested that a stricture of the gallbladder may impede its drainage, a process which may lead to stasis, infection, and stone formation. The purpose of this report is to present six cases of cholelithiasis in which the cholecystograms manifested anatomical abnormality which could have initiated the disease process. The significant clinical and roentgenological data, and the sketches of the removed anatomical specimens, are presented in Table 1.

DISCUSSION

Demonstration of stones in a normally developed and functioning gallbladder usually presents no significant problem. However, when the gallbladder deviates from the normal by duplication, stricture, infolding, bilobation, or septum formation "compartmentalization", a diseased segment of the gallbladder may become concealed from view during cholecystography. One should be alert to this possibility when the gallbladder manifests an irregular contour or when shadows resembling gallstones are visualized outside the confines of an apparently normal gallbladder silhouette. Undoubtedly, the majority of these deformities are congenital in origin but it also can be reasonably assumed that many are produced by repeated intra- or perivesical inflammation with subsequent cicatrization.

The term "compartmental" gallbladder was used by Gordon[6] who reported three cases of cholelithiasis with unusual roentgen findings. This term is completely descriptive of what one finds roentgenologically. However, most of the gallbladders examined postoperatively have a wide communication between the "compartments" which suggests that the term may convey a misleading idea of the actual anatomical findings. Septal or strictured gallbladder seems to be a more appropriate appellation than "compartmental".

In some instances the diseased segment may form a completely isolated compartment as has been shown in Case 4 of this series. Sometimes the partition of the gallbladder seems to be physiological in nature (Fig. 1) for which no apparent explanation can be found on inspection of the removed specimen (Fig. 2). In this case, a foramen 1.5 cm. in diameter was found between the normal functioning proximal segment and the larger nonfunctioning distal part. Apparently one of the stones was lodged in the foramen and had completely occluded it, causing failure of the contrast material to reach the distal segment of the gallbladder.

A reverse of this situation was noted in Case 6 in which a large stone was lodged in the neck of the gallbladder where it snugly occupied the entire proximal compartment of the vesicle. When the gallbladder was removed, there was bile within this compartment. Due to stricture of the gallbladder between the neck and the body, the stone was incarcerated. Pressure from the rough

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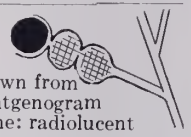
Doctor Nevin is Director; Doctor Bump, preceptor at the University of Wisconsin, is Chief of Surgery; and Doctor Schiek is Attending Surgeon at St. Mary's Hospital.

TABLE 1—*Data on Six Cases of Cholelithiasis in Which the Cholecystograms Could Have Initiated the Disease Process*

Case No.	Sex	Age of patient	Date of exam.	Pertinent symptoms	Roentgen findings	Summary of Pathological report	Sketch of the removed gallbladder Stones in solid black*
1	F	28	Oct. 1, 1959	Colicky pain RUQ for two weeks, nausea and vomiting.	Concave deformity of the lateral aspect of the gallbladder due to stones.	Stones, fibrous tags in midportion of the gallbladder. The wall is infiltrated with chronic inflammatory cells.	Stone: radiolucent
2	F	62	Oct. 9, 1959	Intermittent pain in the pit of stomach one year. Indigestion for 48 hours prior to examination.	Concave deformity of the lateral aspect of the gallbladder due to stones	Surgery not yet performed.	 Drawn from roentgenogram Stone: radiolucent
3	F	56	Apr. 11, 1961	Bilateral lower abdominal cramps for two weeks.	Gallstones demonstrated only by means of spot roentgenography and after fatty meal.	Fibrosis of lamina. Propria and subserosa, septum with mucosa in both sides. Scattered Rokitansky Aschoff sinuses, stones.	Radiolucent stones
4	F	38	Apr. 21, 1961	"Indigestion" for two and one-half weeks and heavy sensation RUQ.	Infolding of the gallbladder with two large radiolucent stones.	Infolding of the gallbladder and stones. A small compartment of gallbladder containing three small stones.	Radiolucent stones
5	F	48	Sept, 1, 1961	Intermittent RUQ pain for six years. Palpable sausage shaped mass right side of abdomen.	Gallstones beyond the confines of an apparent normal gallbladder.	An incomplete septum at the junction of the neck and body of the gallbladder. The fundus contained many stones and bile.	Ring-like stones
6	F	82	Sept. 13, 1961	Sharp intermittent pain in the epigastrium of 24 hours duration.	A single stone in the neck of the gallbladder.	Perforation of the neck of the gallbladder, mucosal ulceration and necrosis adjacent to perforation. Gallbladder contained white mucoid material.	Arrow points to walled off area of perforation.

*Portion of the gallbladder visualized during roentgenography appears in crosshatching.

surfaces of the stone caused a perforation of the neck. This allowed leakage of the bile to a walled-off area of the peritoneal cavity. The distal portion of the gallbladder contained white mucoid material (white bile) indicating failure of the bile to reach this segment. It is most likely that stricture of gallbladder plays a part in the mechanism whereby a large stone perforates the gallbladder and bores its way into the duodenum. This usually leads to gallstone ileus as described by Rigler et al.[7]

It is of interest to note that when there is complete isolation of a compartment, contrast material is usually not found in that segment. But, in Case 4 we noted the presence of bile and three radiolucent stones in a small totally closed segment of a gallbladder which also contained two large stones in two of the three other communicating compartments. An important point of radiological interest is demonstrated in Case 3. The routine roentgenograms of the gallbladder in the left posterior oblique, decubitus, and upright positions failed to demonstrate any abnormality of the gallbladder. However, spot roentgenography with the use of a pressure cone demonstrated a classical roentgen appearance of a double gallbladder (Fig. 3) within whose infoldings two radiolucent stones were suggested. A study made following the ingestion of a

Fig. 1—The outline of an apporently normal gallbladder is shown (between arrows). Note the ring-like calcifications of stones in the right lower quadrant a cansiderable distance fram the gallbladder.

fatty meal (Fig. 4) revealed strong contraction of the vesicle with definite evidence of stones and a peculiar snail-like contracture of the fundus. The latter was interpreted as sandlike stones in a fibrotic recess of the tip of the fundus. This case demonstrates not only the value of spot roentgenography of the gallbladder with the use of the pressure cone but also emphasizes the usefulness of the fatty meal in cholecystography and serves to discourage the recent tendency to omit the latter procedure.

Finally, there is the gallbladder which shows an apparent normal function without evidence of stones; but on close inspection, one can find a concave deformity of a portion of the wall breaking the usual graceful peripheral convexity of the normal contour. This may be interpreted erroneously as a serosal adhesion; but when this deformity is found, the diagnosis of cholelithiasis should be made without hesitation regardless of visualization of any ring-like calcifications beyond the contour of the gallbladder. Examples of these deformities are demonstrated in Cases 1 and 2 (sketches on Table 1).

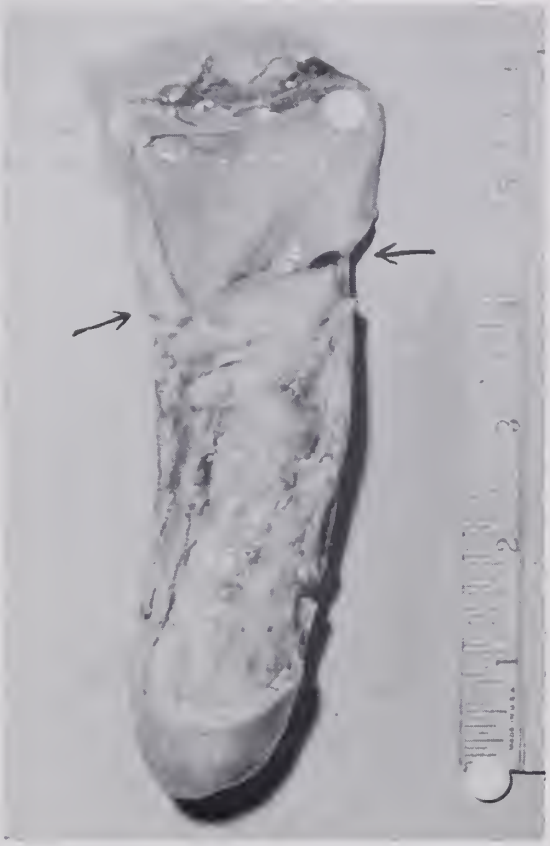


Fig. 2—Photograph of the removed specimen, same case os in Fig. 1. Only the praximal compartment is opened to show the septum (arraws).

It should be emphasized that an atypical gallbladder contour should arrest the attention of the roentgenologist. Its normality should be seriously questioned until one is satisfied with the adequacy of the examination. It is by no means implied that patients who exhibit various deformities of the gallbladder, such as phrygian cap, stricture, infolding and irregular contour, be subjected to unnecessary treatment. However, careful examination of these gallbladders often can be rewarding if the roentgenologist is made aware of the possibility that the visible gallbladder may represent only a part of a viscus whose diseased portion is concealed from view.

SUMMARY

The roentgenographic findings in six patients with deformity of the gallbladder shadow on cholecystography have been presented. In each an associated disease pro-

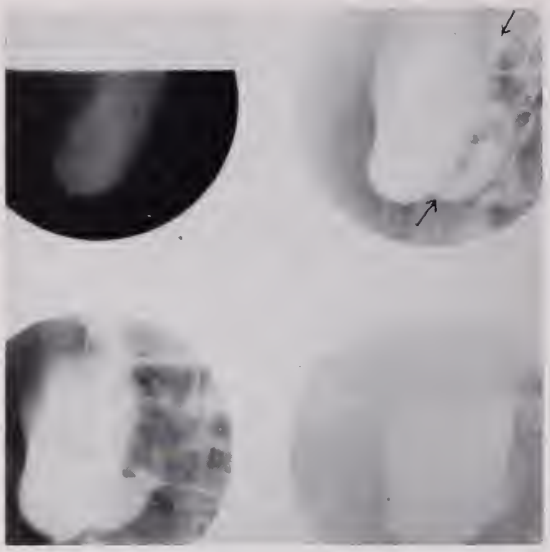


Fig. 3—Spot roentgenogram of the gallbladder using compression device. Note the "characteristic" appearance of a double gallbladder. Radiolucent stones are suggested between the folds (arrows).

Fig. 4—Roentgenogram of the gallbladder following a fatty meal, same case as in Fig. 3. Note radiolucent stones and the snail-like deformity of the fundus of the gallbladder.

cess was demonstrated. The roentgen and pathological findings have been correlated. The importance of the diagnosis of disease in the gallbladder with strictures and septa has been emphasized.

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REFERENCES

1. Boyden, E. A.: Accessory gallbladder; embryological and comparative study of aberrant biliary vesicles occurring in man and domestic animals. Am. J. Anat. 38:177–231 (Nov) 1926.
2. Gross, R. E.: Congenital anomalies of gallbladder: review of 148 cases, with report of double gallbladder, Arch. Surg. 32:131–162 (Jan) 1936.
3. Graham, E. A., and Cole, W. H.: Roentgenologic examination of gallbladder; new method utilizing intravenous injection of tetrabromphenolphthalein, J. A. M. A. 82:613–614 (Feb) 1924.
4. Boyden, E. A.: "Phrygian Cap" in cholecystography; congenital anomaly of gallbladder, Am. J. Roentgenol., 33:589–602 (May) 1935.
5. Else, J. E.. Stricture of the gallbladder, Surg., Gynec. Obst. 19:482–486 (Oct) 1914.
6. Gordon, S. S.: Compartmental disease of gallbladder: cholecystography, gastroenterology 32:750–755 (Apr) 1957.
7. Rigler, L. G., Borman, C. N., and Noble, J. F.: Gallstone obstruction; pathogenesis and roentgen manifestations, J. A. M. A. 117:1753–1759 (Nov 22) 1941.

DON'T OVERLOOK PHAGE TYPING!

Phage typing is an excellent tool for the epidemiological investigation of outbreaks of food poisoning caused by staphylococci or for the investigation of staphylococcal infections.

The result of phage typing in a case of food poisoning can be dramatic. This is an example: A dozen eclairs were purchased at a bakery. Ten were eaten, and the people were hospitalized with acute symptoms of food poisoning. As vomiting subsided, throat cultures were taken, and *S. aureus* was isolated from each patient, from the two remaining eclairs that were purchased, as well as from the eclairs left in the bakery.

Investigation by the health officer revealed an unusually clean bakery, a baker with a sore on his thumb, one helper with a sore on his arm, and the other helper with a sore on the hand. *S. aureus* was isolated from each man, and the biochemical characteristics of these three cultures were similar to those isolated from the patients as well as the eclairs.

The results of phage typing were dramatic. The cultures from the patients and eclairs were phage type No. 29, the cultures from the baker's two helpers were nontypable, but the culture from the baker's thumb was phage type No. 29. The baker, then, was the link in this episode of food poisoning—State of Wisconsin Laboratory of Hygiene, *Newsletter* 1:4 (Sept) 1962.

Sponsored by Section on Pathology
State Medical Society of Wisconsin

CLINICOPATHOLOGIC CONFERENCE

Guest Editor: BERNARD KALFAYAN, M. D.
La Crosse, Wisconsin

CASE PRESENTATION*

A 68-year-old housewife entered the hospital because of progressing weakness of five days' duration.

She had been in excellent health all her life until five months previously when she had fallen down a flight of stairs and struck her back. She was not unconscious and was brought to the hospital immediately. X-ray films of the spine revealed a compression fracture of the first lumbar vertebra with senile osteoporosis. She was at bed rest for two weeks and gradually became ambulatory with the aid of a corset.

At this time the blood pressure was 140/80, and complete physical examination was within normal limits. The hemoglobin level was 13.4 gm. per 100 ml.; hematocrit reading 41%; white blood cells 13,300 per cu. mm. with normal differential count; serum calcium 9.9 mg. and phosphorous 3.1 mg. per 100 ml.; alkaline phosphatase 4.8 KA units; and total serum protein 6.8 gm. with albumin 4.7 gm. and globulin 2.1 gm. per 100 ml. The urine was acid with a specific gravity of 1.028; it was free of albumin, sugar, casts and blood cells. Her recovery was excellent.

Two months later she was readmitted because of weakness of five days' duration. At night when going to the bathroom she nearly fainted but did not lose consciousness. This was accompanied by vague upper abdominal discomfort and nausea. During the next two days she became weaker, nausea continued, and she stayed in bed. Faintness every time she tried to get up made her call a physician who saw her at home. She denied headaches, dizziness or visual disturbances, and there had been no vomiting, diarrhea or constipation. She denied bloody or tarry stools. There were no genitourinary complaints. She had no pain, fever, dyspnea, cough or edema. She was alert, pleasant, cooperative, and afebrile. The pulse was slow, regular and of good quality. The blood pressure was 100/60. Physical examination showed no unusual findings, and hospitalization was advised but she refused.

Two days later, after weakness had increased and vomiting and diarrhea had begun, she entered the hospital. She was thirsty, drowsy and still afebrile. The eyeballs were soft and the skin inelastic. Blood pressure was barely detectable at 90/70. The pulse was very weak. She was not cyanotic. Sinus rhythm was present.

X-ray films of the chest and a gastrointestinal series demonstrated no unusual findings. Electrocardiogram interpretation: sinus rhythm, rate 70, PR 16, QRS 0.11, prolongation of the QT interval and nonspecific ST segment and T wave changes. Laboratory returns: blood urea nitrogen 140 mg., blood sugar 180 mg. per 100 ml.; sodium 110, potassium 2.4 and chlorides 61 mEq./l.; carbon dioxide 11 mM./l.; hemoglobin level 20 gm. per 100 ml.; hematocrit reading 55%; white blood cells 18,050 per cu. mm. with 86 segmented and 7 nonsegmented neutrophils, 5 lymphocytes and 2 monocytes. The urine was acid with a specific gravity of 1.014; a trace of albumin but no sugar was present; and 30 to 35 white blood cells and 60 to 70 red blood cells per high-power field and occasional hyalin and granular casts were found in it. Feces showed no reaction to guaiac but vomitus reacted 4+.

The patient was given intravenous infusions of sodium chloride, potassium chloride, one-sixth molar lactate and 5% dextrose in water with 20 units of regular insulin.

During the initial four hospital days, daily urinalysis showed similar findings with acid reaction, specific gravity ranging between 1.008 to 1.014, traces of albumin, no sugar and multiple red and white cells

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and occasional casts. Daily blood chemistries varied little with sodium ranging between 122 to 128, potassium 1.6 to 2.4 and chloride 82 to 96 mEq./l.; blood urea nitrogen 150 to 185 and fasting blood sugar 55 to 110 mg. per 100 ml.; and carbon dioxide 10 to 16 mM./l. The white blood cell count remained elevated at 15,000 to 17,000 per cu. mm. with neutrophilic granulocytosis and a mild shift to the left in the differential blood count. Penicillin and streptomycin were given from the first day of admission and on the fourth hospital day a urine culture was reported sterile. Culture of feces was free of pathogens.

With this treatment the leukocytosis and the urinary findings persisted, but the blood chemistries showed improvement. The sodium ranged from 134 to 142, potassium 2.1 to 3.3 and chloride 94 to 104 mEq./l.; blood urea nitrogen 150 to 80 mg. per 100 ml. and carbon dioxide 17 to 22 mM./l.

On the seventh hospital day penicillin and streptomycin were discontinued and a urine culture five days later grew Escherichia coli. Nitrofurantoin (Furadantin) was given and the white blood cell count and urine returned to normal. The blood electrolyte levels became normal, but blood urea nitrogen did not drop below 33 mg. per 100 ml. The patient regained strength and was again able to sit in a chair. On the twenty-second hospital day, because of persistent diarrhea, a barium enema was done and a constricting lesion in the rectosigmoid was found. At proctoscopy, a large obstructing sessile lesion was seen 15 cm. from the anus. The impression on x-ray studies and on proctoscopy was carcinoma of the rectosigmoid. A biopsy of the lesion was made and the pathology report was "papillary adenoma." An intravenous pyelogram showed delayed excretion of the dye, but after one hour, the size, shape and position of the kidneys, and the intrarenal collecting system appeared normal. The aorta was calcified. A 24-hour urine volume on the twenty-fourth hospital day was 1,790 ml. with 15.5 mEq./l. of sodium, 8 mEq./l. of potassium and 10.0 mEq./l. of chlorides.

As surgical intervention was being considered for the rectal tumor, the patient had a recurrence of weakness, diarrhea, and vomiting; the blood urea nitrogen rose to 79 mg. per 100 ml. and the blood electrolytes, particularly potassium, dropped to previous low levels. Two urine cultures at this time grew E. coli but urinalysis showed few white and red blood cells, and there was no albuminuria. For the second time there was prompt response to intravenous electrolyte infusions with return of strength and appetite. Blood sodium, chloride, and potassium values became normal, but blood urea nitrogen remained 40 to 45 mg. per 100 ml. and carbon dioxide 18 to 20 mM./l. The patient was discharged from the hospital much improved and was given potassium chloride orally. She was later seen in the clinic on two occasions; both times she was cheerful and well, but the blood urea nitrogen remained 35 to 40 mg. per 100 ml.

Five days after her last clinic visit and three months after her first hospital admission for weakness, she was readmitted to the hospital for recurrence of all her symptoms. She could not stand on her feet. She was dehydrated, afebrile, and free of pain. Laboratory examinations at this time revealed a hemoglobin level of 16.3 gm. per 100 ml.; hematocrit reading 44%; blood urea nitrogen 180 mg. and blood sugar 272 mg. per 100 ml.; chlorides 61.8, sodium 111 and potassium 3.3 mEq./l.; and carbon dioxide 5 mM./l. The urine was acid with a specific gravity of 1.010; there was a trace of albumin but no sugar. The urinary sediment contained 80 to 100 white blood cells and 50 to 60 red blood cells per high-power field but there were no casts. She was again given intravenous fluids and electrolytes, but this time she did not respond to treatment. Two days after admission, her blood urea nitrogen was still 180 mg. per 100 ml.; chlorides were 122, sodium 144, and potassium 3.8 mEq./l.; and carbon dioxide was 8 mM./l. On the day preceding death the urine output was 800 ml. She became drowsy, comatose, and died.

DISCUSSION

Dr. Sigurd E. Sivertson: This case presents a 68-year-old white woman who enjoyed good health until the last three months of her life.

Let us consider the first admission unrelated to her subsequent problems; the blood pressure was normal and x-ray films showed osteoporosis commensurate with age. The cause of her fall at this time was accidental and none of the subsequent pathology was present.

The second admission involved events leading to her terminal illness. The symptoms described were vague and not characteristic of a specific entity; they were consistent, however, with renal failure and fluid and electrolyte disturbance. The weakness and faintness, particularly in an upright position, strongly suggested circulatory insufficiency. Physical findings excluded congestive heart failure as a factor for this, but confirmed the presence of dehydration. Diarrhea was mentioned for the first time, but nowhere in the protocol was there information concerning the frequency, volume, and character of the stools which is so important in fluid and electrolyte disturbances. Similar data concerning emesis were missing. Absence of edema was significant and signifies that hemodilution was not a consideration.

Most significant of the laboratory studies was the blood urea nitrogen of 140 mg. per 100 ml. which points to the kidney. Electrolyte studies showed hyponatremia, hypokalemia, hypochloremia, and acidosis; in the presence of clinical dehydration and elevated hemoglobin and hematocrit reading, these electrolyte reports represented true depletions. Blood sugar at this time was elevated, but later it was low, normal, and high. This is a curious sequence of events, making one wonder if they were either influenced by intravenous glucose administration or were a genuine part of the profound metabolic disturbances. Polymorphonuclear leukocytosis was present and was noted again on subsequent admissions.

I would call your attention to the urinary findings of the second admission, consisting of albuminuria, white and red blood cells, and casts in significant numbers. Note closely the specific gravity of only 1.014, in the presence of marked dehydration; in none of the later urinalyses does the specific gravity go higher and all are lower. Renal disease and failure are again strongly suggested.

Blood chemistries, except for response to treatment during the second admission, continued to show the same findings described previously. There were other significant findings noted for the first time. Material obtained by gastric suction reacted 4+ to guaiac, suggesting the presence of a bleeding gastric lesion—either neoplasm or bleeding diathesis associated with other conditions,

Fig. 1—Roentgenogrom depicting o lorge obstructing lesion of rectosigmoid, impeding flow of barium.

possibly uremia. The urine culture grew E. coli and a culture of feces showed no pathogens. Quantitative measurements of urinary excretion of sodium, potassium, and chloride on this one occasion were low, rather than increased, and the barium enema showed constricting carcinoma of the proximal rectum. I would like the roentgenologist to comment on how sure he was about this being carcinoma and whether the location would indicate retroperitoneal extension and involvement of one or both ureters. Also, I would like his comments on the possible penetration of this lesion into the bladder.

Dr. Edward M. Anderson: This was a large neoplasm in the distal sigmoid and proximal rectum that impeded the flow of barium to such an extent that it was impossible to fill the entire colon. The lesion was several cm. in length and had the appearance of a large carcinoma involving most of the intestinal wall (Fig. 1). Retroperitoneal extension or involvement of ureters was not suggested from these films but it should not be ruled out.

Doctor Sivertson: An intravenous pyelogram certainly is consistent with poor renal function. Was this due to poor renal arterial blood supply, renal vein thrombosis, or renal parenchymal disease?

Doctor Anderson: The findings on intravenous pyelogram can be produced either by renal parenchymal disease or by vascular obstruction.

Doctor Sivertson: The third admission was similar to the second with one notable exception—the patient failed to respond to

treatment, lapsed into coma, and died. The protocol concluded with a dangling tantalizer which read: "On the day preceding death, the urine output was 800 ml."

For brevity's sake, it would be agreeable to consider this chronic renal disease, due to pyelonephritis, acute and chronic. In the elderly, chronic renal disease is reportedly almost always due to chronic pyelonephritis—a provocative and controversial statement made by Bedford and Caird[1] in a study of many autopsies performed on elderly patients. Nephro-arteriosclerosis, on the basis of age, was very likely also present. This would, however, defeat the purpose of a clinicopathologic conference in which a discussion of possible diagnoses and, particularly in this case, relationship to carcinoma of the rectum is in order.

I can find no distinct evidence, and Doctor Anderson concurs, to suggest obstructive nephropathy of ureters or ureterobladder junction produced by the rectal malignancy as demonstrated in the x-ray findings. Profound electrolyte depletions such as this patient had are not seen in lower urinary tract obstruction unless other causes are present. Malignancy, however, can produce a hyponatremia and impaired renal tubular function, as has been recently recognized, particularly in the case of bronchogenic carcinoma.[2] The mechanism for this is not known, but it is postulated that it stimulates the release of antidiuretic hormone from the pituitary; the electrolyte derangement in such circumstances, particularly the hyponatremia, however, is less profound and complex and more easily corrected. I have not found reports of rectal carcinoma doing this. If a patient with a malignancy exhibits a rather sudden progressive and fatal uremia, the possibility of an acute generalized vasculitis with an extensive necrotic glomerulitis might also be suspected.[3] The electrolyte and urinary findings in this patient were not those of a predominant glomerular defect, but were consistent with tubular defect. There was nothing in the peripheral blood count, such as eosinophilia, or in other physical findings to suggest vasculitis. Metastases to the adrenals or pituitary were other possible causes. If the adrenals were destroyed by metastases, however, the hyperglycemia is not adequately explained. There were no studies of adrenal function. One may assume that the condition of the patient precluded exhaustive investigation. No x-ray studies of the head, for change in size of the sella, were recorded.

Malignant lymphoma, infiltrating both kidneys without other evidence of the disease, is a rare condition and I would defer such diagnoses to autopsy studies.[4]

In a puzzling case of uremia with normal blood pressure, potentially reversible types of renal insufficiency should always be considered. Primary hyperparathyroidism, vitamin D poisoning, milk-alkali syndrome, and others to be mentioned later, are considerations. There is no finding here, in either x-ray films of the skeleton or analyses of the blood, to substantiate either of these. Acute or subacute bacterial endocarditis must also be considered, but there is no mention of cardiac murmur and the course was not febrile. Postrenal obstruction has previously been mentioned. Acute urinary tract infection, superimposed upon chronic nephritis or congenital polycystic disease of the kidneys, is a consideration. I think the latter may be dismissed by the absence of palpably enlarged kidneys and the appearance of normal size and shaped kidney outlines in the intravenous pyelograms.

It must be emphasized that renal damage may be of varying and unpredictable degree, especially in relation to electrolyte imbalances. Thus, the kidney can lose or retain water, sodium, chlorides, phosphates, calcium, potassium, or amino acids. The absence of edema, hypertension, marked albuminuria, and the presence of profound multiple electrolyte disturbances suggests that the major defect was in the renal tubules, augmented by vomiting and diarrhea. Chronic and acute pyelonephritis could produce this without the kidneys being contracted. I would feel more secure, however, if the kidney size was diminished and so reported on the intravenous pyelogram. The urinary findings and positive culture were consistent with this diagnosis. Hypertension is present in only about 50 per cent of cases of chronic pyelonephritis[5] and so it need not be present in this patient. Only one quantitative urine excretion for sodium, potassium, and chloride was done and low values were found; this was on the twenty-fourth day of the second admission, when the fluid and electrolyte problems were most likely corrected as reported.

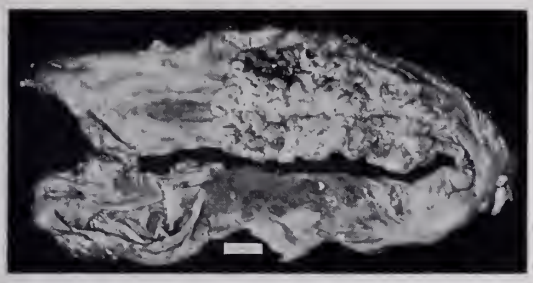

Fig. 2. Gross specimen of colon. There is a sessile villous adenoma involving a large segment af distal calan.

Beeson[6] has said of pyelonephritis: "Its outstanding characteristics are indolence and extreme chronicity; it is not uncommon for it to proceed to a stage of severe renal damage without any preceding illness or disability which can be identified, in retrospect, as having been a manifestation of acute pyelonephritis." It should also be considered in the presence of marked disturbances in tubular function with subsequent acidosis and the inability to conserve electrolytes which result in a variety of disorders. Some of these are Lignac Fanconi's syndrome (cystinosis), osteomalacia, Milkman's syndrome, salt-losing nephritis, secondary hyperparathyroidism, renal rickets, infantilism, and osteosclerosis.

Despite these apparently dogmatic remarks, I am uneasy about making two diagnoses in this patient; but lacking a satisfactory single diagnosis, I must conclude that two independent lesions were present. The first is chronic and acute pyelonephritis with predominant tubular failure, and the second is an obstructing carcinoma of the rectosigmoid.

PATHOLOGICAL DISCUSSION

Dr. Bernard Kalfayan: The significant autopsy findings were confined to the distal colon and kidneys.

In the rectosigmoid there was a large sessile papillary tumor covering diffusely the mucosa of a 19 cm. long segment of colon. It was soft and villous in character and was free of ulceration and induration (Fig. 2). Microscopically the tumor was a typical villous adenoma with branching epithelial fronds lined by uniform mucus-secreting columnar cells (Fig. 3). There were no anaplastic or invasive features. With mucicarmine stain there was abundant

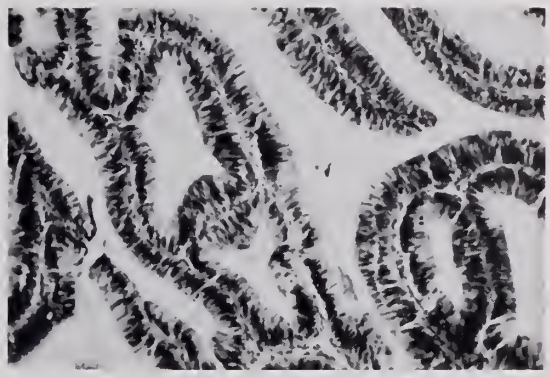

Fig. 3—Phatamicragraph of villous adenoma. The tumor has an intricate pattern of many delicate branching papillary processes lined by uniform mucus-secreting columnar cells.

carminophilic material within the cytoplasm and on the surface of the epithelial cells.

The kidneys were similar in gross and microscopic structure and together weighed 240 gm. The capsule stripped with ease, exposing a smooth outer surface. On sectioning, there were multiple patches of congestion that stood out in sharp contrast with the generally pale parenchyma. The cortex was about 4 mm. in thickness. The pelvis and calyces were not dilated but appeared congested. Microscopically there was a generalized chronic interstitial inflammation of a relatively mild degree. It was associated with increased vascularization and mild patchy fibrosis. Granulocytes were scarce and there was no suppuration. Glomeruli and proximal convoluted tubules were intact. Many tubules of the distal nephron were lined by flat regenerating epithelium and a few of them revealed degenerative changes with granular acidophilic debris or coagulated homogeneous precipitate in their lumen. There was no tubular necrosis and no significant epithelial vacuolization. There was no vasculitis. The anatomic changes in the kidneys were those seen in pyelonephritis of moderate severity that was largely healed, with mild residual chronic inflammation.

The adrenals and pancreas were normal grossly and microscopically. There was pulmonary edema with small intra-alveolar hemorrhages and there was one large patch of mucosal hemorrhage in the descending colon, both of which were attributed to uremia. There were no other noteworthy findings at autopsy.

In recent years it has been recognized that large papillary adenomas of the rectum and

rectosigmoid may cause severe electrolyte depletion which may prove fatal if the tumor is not resected. With removal of the tumor, the electrolyte disturbances are readily controlled and a permanent cure is effected. Recent literature has been adequately reviewed by Finley and O'Connor,[7] Shnitka et al.,[8] Wells et al.,[9] and Carey and Burbank.[10] Judging from these studies it appears that in the English literature there are at least 23 documented cases of large villous adenomas of the distal colon associated with serious electrolyte depletion, dehydration, and azotemia. The condition is perhaps not as rare as believed since this is the second case I have seen in four years. Unfortunately the causative relationship of the electrolyte loss and the large villous adenoma of the rectum was not recognized in the first case which also proved fatal.

The clinical manifestations of patients suffering from this interesting disorder have been those primarily related to hypersecretion of mucus, severe electrolyte depletion, and dehydration. Chief complaints have been diarrhea and passing mucus through the rectum, severe weakness, nausea, vomiting, and confusion. In all cases reported, the tumors have been situated in the rectum or rectosigmoid. Some of the tumors have been entirely benign while others have revealed focal malignant features, some with metastases. In all cases, serum sodium and chloride values have been regularly low and serum potassium values have ranged from normal to very low levels. It has been shown by actual measurement of electrolytes in the mucus passed through the rectum or mucus obtained directly from the tumor, that with the excessive production of mucus by the neoplastic cells, large amounts of electrolytes are also excreted and lost to the body economy. This has resulted in low serum electrolytes, low urinary output of electrolytes (a point of considerable importance in the differential diagnosis of the present case), and in severe dehydration with reduced blood flow to the kidneys and azotemia. In all cases, blood urea nitrogen has been elevated and patients have died in uremia. No significant histological changes have been demonstrated in the kidneys in those cases where autopsy was performed.

It is not known whether the excessive amount of mucus and electrolytes lost from the villous adenoma is merely a reflection of the large surface area presented by the papillary adenoma, or whether a qualitative difference exists between the secretions of normal colonic mucosa and those of the papillary adenoma. As observed by Wells,[9] the location of the tumor in the terminal colon permits no reabsorption of the excreted electrolytes, water and mucus, and might point more in favor of a quantitative difference between the two.

Doctor Sivertson: Were the urinary findings coincidental and misleading?

Doctor Kalfayan: There is no doubt that the patient had an active pyelonephritis, but this was a run-of-the-mill inflammation of the kidney that was well controlled by antibiotics and had produced no significant damage to the kidney parenchyma. Pyelonephritis of this sort does not produce severe electrolyte loss with fatal outcome. It is likely though that the pyelonephritis may have triggered or aggravated a latent condition that would have become manifest clinically sooner or later without the pyelonephritis.

FINAL DIAGNOSES

Large papillary (villous) adenoma of rectosigmoid with severe electrolyte depletion, dehydration, and uremia, and chronic pyelonephritis.

1836 South Avenue.

REFERENCES

1. Bedford, P. D., and Caird, F. I.: Valvular Disease of the Heart in Old Age, Boston, Mass., Little Brown & Company, 1960.
2. Rees, J. R., Rosalki, S. B., and Maclean, A. D. W.: Hyponatraemia and impaired renal tubular function with carcinoma of bronchus, Lancet 2:1005–1009 (Nov 5) 1960.
3. Case Records of the Massachusetts General Hospital (Case 43451), New England J. Med. 257:935–940 (Nov 7) 1957.
4. Wolfsohn, A. W.: Uremia due to renal lymphomatosis, Ann. Intern. Med. 53:197–203 (July) 1960.
5. Cecil, R. L., and Loeb, R. F.: A Textbook of Medicine, 10th Ed., Philadelphia, Pa., W. B. Saunders Company, pp. 1076–1079.
6. Beeson, P. B.: Factors in pathogenesis of pyelonephritis, Yale J. Biol. & Med. 28:81–104 (Nov) 1955.
7. Findlay, C. W., and O'Connor, T. F.: Villous adenomas of large intestine with fluid and electrolyte depletion, J. A. M. A. 176:86–90 (May 6) 1961.
8. Shnitka, T. K., et al.: Villous tumors of rectum and colon characterized by severe fluid and electrolyte loss, Surg. Gyn. & Obst. 112:609–621 (May) 1961.
9. Wells, C. L., Moran, T. J., and Cooper, W. M.: Villous tumors of the rectosigmoid colon, with severe electrolyte imbalance. Cause of unexplained morbidity and sudden mortality, Am. J. Clin. Path., 37:507–514 (May) 1962.
10. Carey, R. J., and Burbank, C. B: Mucus-secreting villous adenoma of colon: presenting as circulatory collapse, New England J. Med., 267:609–611 (Sept 20) 1962.

Editor
H. F. HARDMAN, M. D., Marquette University

COMMENTS ON TREATMENT

ANGIOTENSIN

By ALBERT C. YARD, M. D., Ph. D.

Milwaukee, Wisconsin

ANGIOTENSIN was probably the substance responsible for the rise in blood pressure observed in 1898 when crude extracts of kidney tissue were injected into animals. Within the past year, pure angiotensin has been marketed for use in treating hypotension. Between 1898 and the present, and particularly within the last decade, angiotensin has been the subject of intensive pharmacological and chemical investigations. The chemical studies established initially that the compound is a polypeptide; later, the exact amino acid sequence. Finally, after synthesis of the compound, the naturally occurring and synthetic substances were shown to have identical biologic activity. Subsequently some of the features of the molecule which are essential for this biologic activity were outlined by synthesizing and testing polypeptides which, for example, differ from the parent compound by the substitution of one amino acid for another, or merely by one functional group of one amino acid. It is clear from these investigations that the original kidney extracts contained an enzyme, renin, the substrate for which is a plasma protein of the α globulin family, angiotensinogen. The agent formed in this interaction is known as angiotensin I, a polypeptide composed of 10 amino acids. Although angiotensin I lacks pressor properties, it is rapidly converted in plasma to the active form, an octapeptide, angiotensin II.

Because angiotensin is a naturally occurring substance of extreme potency, investigators have speculated on the possibility that it may be part of the physiologic mechanism for regulation of blood pressure. Further, the possibility has been raised that it may be the etiologic agent of some forms of hypertension, particularly renal occlusive or malignant hypertension. To date, there has not been agreement among leading investigators as to the precise role, if any, played by angiotensin either in normal circulatory homeostasis or in hypertension. The third aspect of interest in angiotensin is the therapeutic one; this three-fold interest thus is similar to that which centered around norepinephrine following the discovery of its natural occurrence and role in pathologic processes.

The most prominent actions of angiotensin, as the name implies, are on the vascular system. This substance is probably the most potent pressor agent known; using various methods of comparison, angiotensin has been found to have roughly ten times the pressor activity of norepinephrine, thereby establishing the effective intravenous dose at a fraction of a microgram per kilogram.

The site of action of angiotensin is mainly on arterioles. The basis of the pressor effect, then, is elevation of peripheral resistance. The pulmonary vasculature has a very limited ability to respond to angiotensin; changes in pulmonary arterial pressure which have been observed following intravenous administration of the drug are considered to be passive. Mesenteric and renal vascular beds are strongly constricted. The effects on coronary flow cannot be succinctly stated without additional study. In spite of strong constriction of skin arterioles, no slough following extravasation of angiotensin has been reported. This may be related to the observation that the vasculature peri-

pheral to the arteriole is not markedly responsive to angiotensin. The pressor response to an intravenous infusion of angiotensin in normotensive humans can be maintained for extended periods of time without need for increasing dosage. Similar reports have appeared with respect to the maintenance of blood pressure in hypotension under a variety of clinical conditions.

Changes in cardiac output do not seem to have a prominent role in the pressor response to angiotensin as indicated by studies in normal human subjects as well as in dogs. Although cardiac arrhythmias have been noted following the induction of extremely high arterial pressure with many vasopressor agents, some investigators have reported that these arrhythmias are less serious and occur less frequently with the use of angiotensin than with other agents.

Much of the basic pharmacology of angiotensin remains to be established. Little is known about precise mechanism of action of the compound on vascular smooth muscle. No blocking agent for angiotensin is known as yet, but the introduction of such an agent should aid greatly in our attempts to understand the action of this substance. At present not only pressor agents but also compounds capable of reducing adrenergic vasoconstriction are being evaluated clinically in the management of shock. The place in therapeutics which is achieved by angiotensin will be governed partially by the results of these investigations.

REFERENCES

1. Page, Irvine H., and Bumpus, F. M.: Angiotensin, Physiological Reviews 41:331–390, 1961.
2. Wood, J. E., and Ahlquist, R. P. (Editors): Symposium on angiotensin, Circulation 25:167–269, 1962.

DIABETIC NEPHROPATHY WITHOUT MANIFEST DIABETES

ELLENBERG, MAX, *Diabetes*, 11:197 (May–June) 1962.

There is universal agreement that the Kimmelstiel–Wilson lesion of nodular glomerulosclerosis is the most reliable and constant of all the pathologic features associated with diabetes. However, the lesion has also been encountered at autopsy in cases where there was no evidence of diabetes during life.

The author presents 2 cases* of patients with a normal blood picture, evidence of renal and cardiovascular involvement and normal fasting blood sugar. Because other facets of the clinical picture suggested diabetes a glucose tolerance test was obtained and found to be abnormal in both cases.

A third case reported is that of a hypertensive delirious female patient found to have neither sugar nor acetone in the urine. The patient died shortly after admission and at autopsy classic nodular glomerulosclerosis and an elevated blood sugar were found.

Because of his experience with these cases the author suggests that the few cases in which it has been stated that the lesion occurred in nondiabetics may be due rather to lack of suspicion of diabetes in the face of absence of overt manifestation of disturbed carbohydrate metabolism. Awareness of this association may help resolve obscure clinical problems. The author states that diabetes should be suspected in the differential diagnosis of any renal lesion of uncertain etiology especially in the presence of a family history of diabetes, retinopathy, neuropathy (absent deep reflexes), peripheral gangrene, or arteriosclerosis.

These observations suggest that diabetes is a generalized disease and that the facets of the illness other than the disturbed carbohydrate metabolism are concomitants rather than complications.—*International Medical Digest* 78:489 (Nov) 1962.

* The presence of Kimmelstiel–Wilson nodular glomerulosclerosis was demonstrated by renal biopsy in one case and at autopsy in the other.

The Mount Sinai Hospital, New York, N. Y.

POISON CONTROL SEMINAR

As a highlight of Poison Control Week, which the Public Health Service of Wisconsin has designated to begin March 17, the State Board of Health has planned a poison control seminar to be held Wednesday, March 20, at the State Medical Society of Wisconsin headquarters at Madison.

The State Medical Society and other interested groups are co-sponsoring the seminar.

The program will begin at 9:30 a.m. with a keynote address to be followed by a discussion on the legislative approach to poison control.

Afternoon workshops from 1 to 3 p.m. will focus on rescue and first aid in poison emergencies, in the emergency treatment room, and education and local planning. "What the Reports Tell Us" is the title of the closing session from 3 to 3:30 p.m.

Specific information regarding the seminar can be obtained by writing Mr. Jan Marfyak, State Board of Health, Madison 2, Wisconsin.

THE PRESIDENT'S PAGE . . .

The Associated Professions

BY REQUEST OF the Wisconsin Pharmaceutical Association, the following article was prepared for publication in *Wisconsin Pharmacist.* Since its message is of interest to physicians as well as pharmacists, it is being reprinted below.

* * *

One of the pleasant and instructive opportunities to visit other professional organizations in our neighboring states occurred during our visit to the Michigan State Medical Society in Detroit during October, 1962.

The Secretary of the Michigan Association of the Professions (MAP) who is also Public Relations Counsel for the Michigan State Medical Society, Mr. Hugh Brenneman, graciously took two or three hours from his busy schedule to report the origin of MAP and its development to the present time. Mr. Brenneman has just accepted an invitation to discuss the purposes and accomplishments of the Michigan Association of the Professions at the final meeting of our Wisconsin Work Week of Health on February 23 at the Medical Society Headquarters in Madison. His remarks will be part of the Conference of County Medical Society Presidents and Secretaries. It is my personal hope that one or more of your officers and staff can be present to hear Mr. Brenneman.

Incidentally, the Fourth Annual Congress of the Professions is to be held in Lansing, Mich., on February 8 and 9, 1963, and I would urge your officers to attend because preliminary planning for similar organizations is underway in many other states.

The recent scientific explosion is even more spectacular than the population explosion. Professions that were formerly closely associated have drifted apart. To this observer it seems that such a drift may be occurring between the pharmacy and medical professions. The attention of the membership of the medical profession is being called to this situation and I invite your officers and members to consider the possibility of joining with other professions in Wisconsin in an interprofessional organization.

The five original professional groups in Michigan—engineering, the law, architecture, medicine and dentistry—have been joined by pharmacy and veterinary medicine recently and the membership now exceeds 80,000.

(Continued on page 138)

ORAL HYPOGLYCEMIC AGENTS IN DIABETIC PATIENTS WITH PULMONARY TUBERCULOSIS

FERIDUN GUROL, et al., Herman Kiefer Hospital, Detroit, Mich., *American Review of Respiratory Diseases*, 85:51 (Jan.) 1962.

The authors give a brief resume of the development of oral hypoglycemic drugs and then give the results obtained after treating 65 diabetic patients thusly.

In 1926, Frank and his associates showed that Synthalin A (decamethylene-diguanidine) had a marked hypoglycemic action when administered orally to depancreatized animals and human diabetics. However, use of this drug was abandoned because of its toxicity. In 1942, Janbon and Loubatieres noted the hypoglycemic action of certain sulfonamides during the treatment of typhoid fever. In 1954 Franke and Fuchs, testing the antibacterial activity of carbutamide (BZ 55), found it had a marked hypoglycemic action, but once again the high incidence of toxic side effects led to its abandonment. Shortly after, however, two related substances, tolbutamide and chlorpropamide, were introduced into clinical use. In 1957, Ungar and his associates found that phenformin (DBI) induced hypoglycemia in man without serious toxic effects.

It is believed that the sulfonylureas act in two main ways: (1) by increasing the production and release of insulin, and (2) by diminishing glucose release from the liver. Phenformin is believed to act differently by increasing anaerobic glycolysis, but unlike insulin, it decreases muscle glycogen deposition and oxygen uptake, and causes a greater increase in lactic acid production.

In the cases of the 65 patients treated, the choice of drug was determined as follows. Mild diabetics who required less than 35 U. of insulin daily and were more than 40 years of age, whose diabetes was recent in onset and who had no history of acidosis were treated with sulfonylureas. Phenformin was used in those of this group in whom sulfonylureas failed, and in those "brittle" diabetics who required two to three doses of insulin per day.

The status of tuberculosis was judged as minimal in 8, moderate in 21, and far advanced in 36. Many of these patients had cardiovascular, renal, or neurologic complications, and also unrelated diseases including amyloidosis, duodenal ulcer, corpulmonale, and hypertension. All received antituberculous chemotherapy throughout the period of study. Twenty-one patients were treated with tolbutamide, 23 with chlorpropamide, 16 with phenformin, and 14 with phenformin and insulin.

No side effects were seen with the sulfonylureas, but some of the patients on phenformin complained of a metallic taste in the mouth. Sometimes nausea occurred, as did vomiting and diarrhea. These effects were found to be dose-related. Throughout the study period (which varied from 3 to 20 months), patients had chest x-rays, sputum cultures, blood sugar estimations, and urinalyses.

At the end of the period it was noted that none of these agents interfered with the healing of the tuberculous process. Of the 65 patients treated, 56 had excellent or good responses, 13 were regarded as failures, and 5 had only fair results. Most of the patients who had never taken insulin responded much better than those who had taken it for a long time, and success was common in those whose insulin requirements were small.

In this study it was found that when the sulfonylureas failed to control the diabetes, the amount of insulin required for subsequent control was greater than the pretreatment level. This observation agrees with the findings of some authors, but is not believed to be generally true.—INTERNATIONAL MEDICAL DIGEST, Vol. 78, No. 6.

THE PRESIDENT'S PAGE *(Continued from page 137)*

Such phenomenal growth together with the wish of still more professional groups to become affiliated demonstrates the value of the organization to the professions of Michigan.

Even the largest professional groups are small in relation to our total population. As an entity, however, they represent a high proportion of the intelligently trained minds of our country and united should be a powerful force in leadership in solving our mutual problems.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

FEBRUARY 1963
Vol. 62 No. 2

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

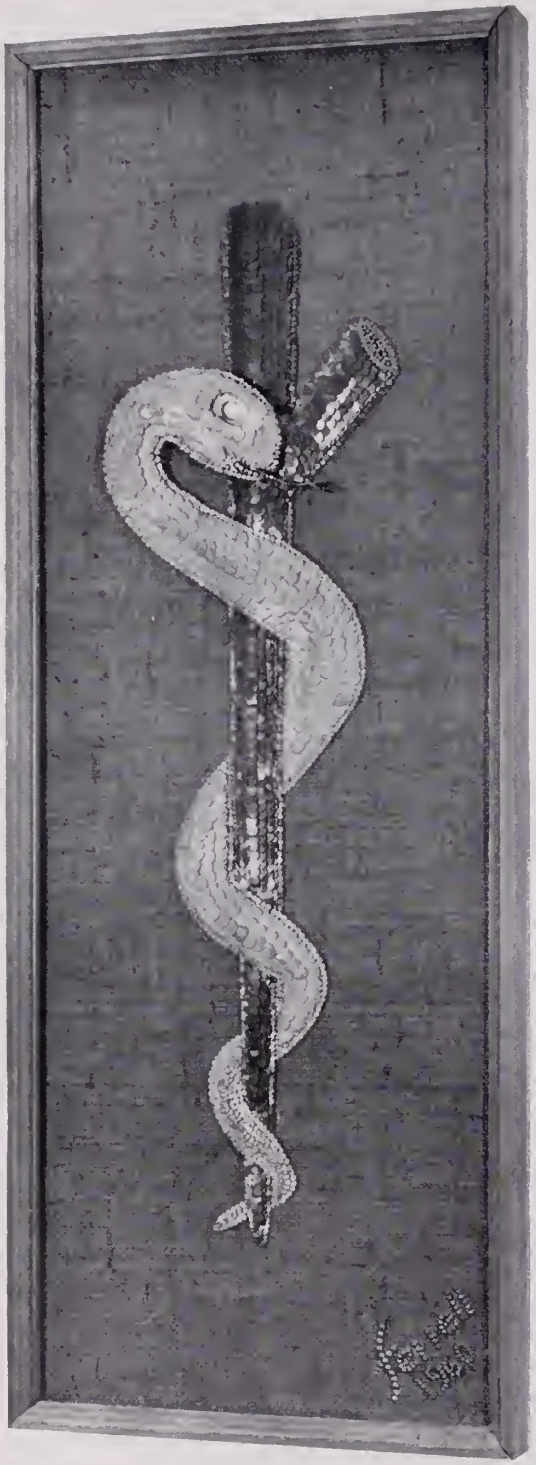
Confreres of the Cloth

SHOULD A patient be told his illness is fatal? What do you say to the parents of a child whose life has slipped away? How do you prepare an anxious family for an event they fear, yet hope won't happen? These and similar questions are foreign to no doctor's practice. Yet when it comes to confronting the patient or his family with the hard fact of reality, there is little in his education that prepares the physician for his task.

Fortunately doctors can, on occasion, enlist the help of clergyman to buttress the courage of the patient or assuage the grief of his family. The solace of religion may give meaning to suffering, or make endurable a shocking turn of events. In this sense the clergy and the physician often find themselves functioning in parallel roles as counselors to the patient and his family. To help members of the ministry accomplish their purpose, a working knowledge of the medical aspect of the problem is essential. Close cooperation between doctors and the ministry, especially in the exchange of the ideas or knowledge the other might find useful, should be eagerly sought.

A valuable first step in this cooperation has been taken by the Wisconsin Heart Association through its sponsorship of seminars for physicians and clergy of all faiths. Entitled "The Pastor and Physician as Counselors to the Chronically Ill Patient and the Family," the first of the series was held with the co-sponsorship of the Kenosha County Medical Society. It featured four distinguished speakers and was followed by a lively panel discussion. Both professional and lay persons in attendance expressed enthusiasm for the ideas developed during the discussion, and the participants felt that a worthwhile project was launched.

It is to be hoped that seminars of this nature become widespread throughout the state, and indeed, the nation. They are interesting, stimulating, and make for a better understanding of the human problems so characteristic of the practice of medicine.—D.N.G.



Donor
ROBERT D. FERRELL, M.D.
Hempstead, New York
1962

STAFF OF AESCULAPIUS

Symbol of the Medical Profession

A unique metal point sculpture of the Staff of Aesculapius, symbol of the medical profession, has been presented to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin by Robert D. Ferrell, M.D., of Hempstead, New York.

The work of original art, which won recognition for Doctor Ferrell at a 1961 exhibition of the American Physicians Art Association in New York, is a three-foot plaque that is distinctive in its simplicity and texture. A serpent of bluish grey galvanized nailheads entwines a dark metal staff, also made of nails, which is mounted on a background of burlap.

Doctor Ferrell, a psychiatrist, is a graduate of Marquette University School of Medicine, Milwaukee. His interest in metal sculpture began in 1956 when he was stationed with the Armed Forces in Germany.

The sculpture will be on display at the Museum of Medical Progress at Prairie du Chien during the exhibit season and at the State Medical Society headquarters in Madison the rest of the time.

* * *

The staff of Aesculapius is not to be confused with a caduceus, which is a herald's wand.

Mythology relates that the Greek God Asklepios (Roman Aesculapius) "studied the healing art and soon surpassed his teacher (Chison), for his patients never died and he even succeeded in recalling the dead." Wherever he went, he was seen with his rugged staff of knotty pine. His fame spread through the Mediterranean area and he is reported to have had many medical sanctuaries. After his death, supposedly ordered by jealous Pluto who had Jupiter destroy him with a thunderbolt, many shrines were built in his honor and a special type of healing was carried on by incubation.

Serpents have been regarded with both fear and admiration since the time of Adam. Because of the annual renewal of its skin, its graceful movements, its speed and its destruction of its prey, the snake was attributed with rejuvenation, convalescence, wisdom and long life. Serpents participated in the rituals that accompanied the healing and curative procedures in the Asklepian temples. In combination, the staff of Asklepios adorned with a serpent has become the symbol of the medical profession.

the Wisconsin Medical Journal

MARCH 1963

VOLUME 62

NUMBER 3

CASE REPORT

Brain Stem Vascular Accident Following Neck Manipulation

By ROBERT A. PRIBEK, M. D.

La Crosse, Wisconsin

DAMAGE to the brain stem following neck manipulation was first reported by Pratt–Thomas and Berger[1] in 1947. Since their initial report of two cases, eight similar cases have been described.[2–6] Four of these 10 cases were fatal. The following additional case is presented to emphasize again this serious and potentially fatal intracranial complication of manipulation of the head and neck.

Case Report. A 63-year-old man entered the hospital because of severe weakness of the right leg. Two days before admission he had a chiropractic adjustment for a "nervous stomach." Immediately after manipulation of his neck, he stood up and became extremely dizzy and ataxic. He could not walk without support. He also noted weakness of the right leg and numbness of the right side of the body. The paresthesias spared the face. There was no blurred vision, diplopia, dysphagia, dysarthria, tinnitus, difficulty in hearing, or loss of taste or smell. On the following day he no longer had vertigo and ataxia. Because of continuing weakness of the right leg and the paresthesias, he finally sought medical attention.

The system review was negative except for vague epigastric distress of many years duration.

Past medical history revealed that he had blurred vision in the left eye for several weeks at age 42. This cleared without residual loss of vision. Two years before the present illness he had had a complete physical examination. No abnormalities were noted at this time according to the examining physician.

Physical examination on admission revealed a slow, unsteady gait due to weakness of the right leg. The pupils were equal and round and reacted to light and accommodation. There was no nystagmus. The visual fields were full to confrontation testing. Funduscopic examination was normal except for minimal pallor of the entire left optic disc. The cranial nerves were otherwise not remarkable. Examination of the deep ten-

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don reflexes revealed a hyperreflexia in the left upper and right lower extremities. There was a Babinski toe sign on the right. A Hoffmann's sign could be elicited bilaterally. Cerebellar function was normal except for slight dysmetria on doing the heel-to-shin test on the right. The Romberg test showed no swaying. No sensory deficit was found despite the complaint of right-sided paresthesias. Tests for motor power disclosed a minimal weakness of the left upper extremity and a pronounced weakness of the right lower extremity. All peripheral pulses including the carotids were easily palpable. A bruit was not heard over the neck vessels.

Laboratory studies revealed a hemoglobin level of 14.6 gm. per 100 ml.; hematocrit reading 42%; white blood cell count 7,900 per cu. mm. with a normal differential count. The sedimentation rate (Westergren) was 10 mm. in 1 hour. A urinalysis, serological test for syphilis, blood urea nitrogen, serum cholesterol, fasting and two-hour postprandial blood sugar were all normal. Free hydrochloric acid was present in a gastric analysis. An electrocardiogram was normal. X-ray examination of the chest, upper gastrointestinal tract, gallbladder, skull, lumbar spine, and cervical spine with special views of the odontoid process were all normal. The cerebrospinal fluid was under normal pressure and contained 56 mg. per 100 ml. of protein. A serological test for syphilis and colloidal gold reaction were normal.

Neurological examination remained unchanged during his hospital stay. He no longer complained of paresthesias after five days. There was gradual return of strength in the right leg and improvement in gait. Follow-up examination after one month showed minimal weakness in the left upper and right lower extremities with residual hyperreflexia. A Babinski toe sign was still present on the right.

Comment. There is considerable evidence that manipulation of the neck can significantly interfere with the blood supply to the brain stem and cerebellum. This was first demonstrated by De Kleyn and Nieuwenhuyse[7] in a study conducted on cadavers. They found that the circulation through one vertebral artery could be severely compromised if the head were over-extended and tilted to the opposite side. Tatlow and Bammer[8] confirmed their findings with postmortem angiographic evidence showing narrowing of the lumen of the contralateral vertebral artery at the level of the atlas and axis when the head was turned to the right or left. Compression and kinking of the neck vessels with head rotation was also demonstrated more recently in an arteriographic study done on patients.[9] The fact that thromboses were found at autopsy in the vertebral-basilar system in three of the documented fatal cases is not surprising. Interference with vertebral artery blood flow causing secondary thromboses at a higher level in the vertebral-basilar system is a logical explanation for the central nervous system damage in these cases. The autopsy examination of the basilar and vertebral arteries in the fourth fatal case was incomplete, but the observed diffuse softening of the brain stem, cerebellum, and upper cervical spinal cord is consistent with a vascular etiology. Fortunately, the majority of the patients with neurologic findings after neck manipulation have lesser degrees of brain stem damage.

Considering the number of patients who receive this vigorous neck manipulation, it is curious that this complication is seen so seldom. The presence of advanced arteriosclerosis does not seem to be a predisposing factor in view of the ages of the patients in the recorded cases (32, 35, 35, 37, 41, 28, 31, 55, 33, and 48 years). Pre-existing vascular disease was not found at autopsy in the four fatal cases. An underlying neurological disease (multiple sclerosis) was present in only one of the reported cases.

To explain the rarity of this occurrence, Green and Joynt[5] suggest that the susceptible patient may have an abnormal vascular pattern such as a single vertebral artery or one effective vertebral artery which constitutes the major blood flow into the basilar system. It is evident that this unusual stress could easily embarrass the blood supply to the brain stem in the presence of such vascular abnormalities.

More detailed examination of the vessels in the neck in autopsy cases is needed in this situation. Vertebral angiography would also be useful to detect variations in the size and course of these vessels. Such studies in future cases could contribute much to the understanding of the mechanism of brain stem vascular damage in these patients.

In view of the finding of thromboses at autopsy in fatal cases, prompt anticoagulant therapy is indicated in patients who are seriously ill on admission. This therapy may prove life-saving.

Summary. A case of damage to the brain stem following neck manipulation is described. Compression of the vertebral arteries is evidently the mechanism responsible for such accidents.

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REFERENCES

1. Pratt-Thomas, H. R. and Berger, K. E.: Cerebellar and spinal injuries after chiropractic manipulation, J.A.M.A. 133:600-603 (Mar 1) 1947.
2. Kunkle, E. C., Muller, J. C. and Odom, G. L.: Traumatic brain-stem thrombosis; report of a case and analysis of the mechanism of injury, Ann. Intern. Med. 36:1329-1335 (May) 1952.
3. Ford, F. R. and Clark, D.: Thrombosis of the basilar artery with softenings in the cerebellum and brain stem due to manipulation of the neck, Bull. Johns Hopkins Hosp. 98:37-42 (Jan) 1956.
4. Schwarz, G. A., Geiger, J. K. and Spano, A. V.: Posterior inferior cerebellar artery syndrome of Wallenberg after chiropractic manipulation, A.M.A. Arch. Intern. Med. 97:352-354 (Mar) 1956.
5. Green, D. and Joynt, R. J.: Vascular accidents to the brain stem associated with neck manipulation, J.A.M.A. 170:522-524 (May 30) 1959.
6. Smith, R. A. and Estridge, M. N.: Neurological complications of head and neck manipulations, J.A.M.A. 182:528-531 (Nov 3) 1962.
7. De Kleyn, A. and Nieuwenhuyse, P.: Schwindelanfälle and nystagmus bei einer bestimmten stellung des kopfes, Acta. Oto-laryng. 11:155-157, 1927.
8. Tatlow, W. F. T. and Bammer, H. G.: Syndrome of vertebral artery compression, Neurology 7:331-340 (May) 1957.
9. Bauer, R., Sheehan, S. and Meyer, J. S.: Arteriographic study of cerebrovascular disease, A.M.A. Arch. Neurol. 4:119-131 (Feb) 1961.

FOR YOUR INFORMATION . . . from the Wisconsin State Board of Health

Family Life Education for High School Youth

PHYSICIANS, like others are challenged by many fast moving, important changes. Perhaps most vital are changes directly affecting the family. For example, there is a marked drop in the average age of marriage for both wives and husbands. Presently, the national average for brides is 19 years and grooms approximately 20. For Wisconsin, the 1960 median ages were approximately 20 and 23 years respectively.

It is important to consider the preventive implications of the following facts about changing families: (1) the establishment of families commonly occurs in young marriages within the first few years; (2) in the national labor force a sizeable number are mothers of young children; (3) many mothers and fathers continue their own education during the early years of marriage; (4) the mode of child-rearing has become increasingly influenced by more adequate knowledge of child needs and development. The challenge is urgent and difficult: How can professional services and community programs take these facts into account sensibly and effectively?

It is obvious that guided preparation for modern parenthood is necessary. Especially do youth require help with their transition from childhood to adulthood. They need to understand much more about themselves as individuals living in a complex, fast-changing society. The more realistically the adolescent can know and accept himself, the more he will be free to build on his strengths, to face his weaknesses and limitations, and to meet the heavy obligations of adulthood.

The Wisconsin State Board of Health has recognized the need for practical, well-timed family life education. While this need is continuous throughout life, it is suggested that there may be tremendous preventive potential in giving concentrated help to those who are in high school. The large objective of the Board of Health program is to stimulate and enable parents, school personnel, and other key adults in the community to give educational help locally to their own young people. They will need encouragement, but not coercion, to avail themselves of such assistance.

Various schools are already making some efforts in the area of family life education. These fall under three main categories: as a unit of the home economics course for girls; as a sex education unit in some science or physical education courses; and as a separate

course mainly on the junior high level. It is not usual, however, for any of these study programs to be based mainly on the needs of the children, nor are discussion opportunities provided to express attitudes and feelings untrammeled by precut adult objectives or judgmental values.

Valid, free communication with young people can feed back important information regarding their needs and potentials. Such feedback can obviously serve many purposes, including ideas for essential modifications in education and rearing of all children. It is obvious that this information could be invaluable in various ways to most physicians.

Our preferred teaching method is that of flexible small group discussions. Many teaching aids are used, i.e., sequential series of films, filmstrips, plays, pamphlets. Occasional joint sessions of youth and parents or teachers are planned for meaningful exchange in a constructive setting. The beginning attempt in this project can be either on a very simple level or a more complex one. For example, a series can begin with no more than three sessions, well defined and well supported by teaching aids and structured procedures. Or the program can project a longer series of sessions in less structured form.

This program can be related to various home-school transition projects fostered by the Division of Child Behavior and Development. The program involving volunteer "reading mothers" in kindergarten, for example, can also use high school students who get an opportunity for first-hand experience in observing and relating to young children.

There are some intriguing opportunities for follow-up, simply because many of the young people, in a year or two, will become husbands, wives, and parents. There should be opportunity to test out the preparatory education in terms of the quick and drastic change of role from dependent child to responsible adult. The physician will be particularly interested in how effective the education has been in terms of receptivity to prenatal parent classes, prenatal medical services, and early child health supervision. To insure good effects, the doctor may want to help establish, support, and guide such program efforts in his own community.—W. O. BROWN, *clinical psychologist and a consultant with the Division of Child Behavior and Development, Wisconsin State Board of Health, Madison.*

REFERENCES

1. Talks with Parents, Wisconsin State Board of Health, Madison 2, Wis.
2. Erikson, Erik H.: Childhood and Society, W. W. Norton and Co., Inc., New York, 1950.
3. Friedenberg, Edgar Z.: The Vanishing Adolescent, Dell Publishing Co., Inc., New York, 1962.
4. Abramovitz, A. B.: Transitions—a focus for prevention, Wisconsin Med. J. 60:381–382 (July) 1961.

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Vascular Ring Anomalies

By GEORGE G. GRIESE, M. D. and BEN R. LAWTON, M. D.

Marshfield, Wisconsin

ANOMALIES of the aortic arch giving rise to compression symptoms of the esophagus and trachea are uncommon. Because these malformations may produce serious morbidity in the first few months of life, early recognition and diagnosis are extremely important. Complete correction of most of these lesions can be effected surgically.

The two cases presented in this report are intended to illustrate the clinical syndrome encountered, the necessity for including vascular ring anomalies in a differential diagnosis, the procedures involved in diagnosis, and finally their surgical corrections.

CASE REPORTS

Case 1. This infant was the product of a normal pregnancy and delivery. She appeared perfectly well until one week of age when the parents noted some rasping breathing. At the end of the second week the child developed marked respiratory distress and cyanosis. She was treated in her local hospital for 19 days; treatment included oxygen, penicillin, and steam. She responded to treatment slowly and then became asymptomatic. She was well for two months when there was a sudden recurrence of difficult, noisy breathing; and she was again admitted to the hospital for emergency care. Six days later her condition became worse, and she was transferred to another hospital.

On admission this four-month-old child was well-developed and well-nourished. There was marked respiratory distress and irritability. The chest showed roughened breath sounds with diminished resonance on the left side as compared to the right side, and the expiratory phase was prolonged throughout with many scattered, coarse rales. While lying in her crib, the child assumed a typical opisthotonic position for respiratory relief; however, her swallowing function was unimpaired. Chest x-ray films showed an early pneumonitis in the right apex and a slight shift of the mediastinum to the right. Because of the respiratory pattern and the two episodes of acute tracheobronchitis and pneumonitis, a vascular ring anomaly was suspected.

Laboratory studies showed a normal urinalysis and a hemoglobin level of 10.6 gm. per 100 ml. Her white blood cell count was 11,000. Tryptic activity in the stool was strongly positive. An esophagram using thin barium revealed persistent narrowing of the esophagus at the level of the aortic arch in the anteroposterior views. In the lateral views there was a pronounced "cookie-bite" deformity of the posterior wall of the esophagus (Fig. 1).

On the tenth hospital day, after clearing of the acute infection, an exploratory operation of the aortic arch area was performed. A double aortic arch was found with the ascending aorta passing to the right of the trachea and descending on the right. There was marked constriction of the esophagus

Fig. 1—Case 1. Barium-filled esophagus showing persistent filling defect in lateral and posteroanteriar views.

From the Marshfield Clinic Foundation for Medical Research and Education. Doctor Griese is a pediatric cardiologist and Doctor Lawton is chief of thoracic surgery.

Fig. 2—Case 2. Arrow points to area of tracheal narrowing. Note also lack of filling defect in the esophagus.

and trachea by the posterior arch which joined the anterior arch and ligamentum arteriosum on the left. The posterior arch and ligamentum were divided, and complete relief of the constriction was obtained. The child tolerated the procedure well.

Her breathing gradually improved over the 10 days she was observed postoperatively, and she was discharged in good condition with negative physical findings except for slight roughness of the breath sounds centrally. Eight days later she was readmitted because of severe laryngotracheobronchitis for which a tracheotomy became necessary. She recovered from this uneventfully and subsequently has been well without unusual respiratory symptoms.

Case 2. This infant was admitted to the hospital for the first time at eight weeks of age with an episode of acute tracheobronchitis. Treatment with oxygen, antibiotics, and steam seemed to clear the condition fairly well. The parents stated that they had noticed noisy respirations when the child was a week old and these had persisted since that time. He was discharged but was readmitted two weeks later with a recurrence of the respiratory infection and symptoms.

His general development was excellent and his color was good. There were some harsh breath sounds and some central rhonchi, but there was nothing else unusual. He had no difficulties in taking his feedings. He preferred to lie in a position of moderate opisthotonos, at which time his respirations seemed easier. Chest x-ray films disclosed a normal cardiac contour and position, and his lungs were clear. There appeared to be some narrowing of the trachea as it entered the chest which was noted as far as the carina (Fig. 2). It was felt that the apparent narrowing might be due to incomplete filling with air since no definite soft tissue mass was seen. On two occasions no filling defects were seen along the entire course of the barium-filled esophagus.

A bronchoscopic examination was performed, and the trachea appeared entirely normal to a level approximately 2 cm. below the sternal notch. At this point the trachea became too narrow to admit the infant bronchoscope. The tracheal orifice was transverse and slit-like in shape. The anterior wall of the trachea was rigid and the posterior wall was normal, flaccid; and with forced expiration met the anterior wall causing almost complete obstruction of the airway. A dose of 2 ml. of propyliodone (Dionosil) was instilled through the bronchoscope, and lateral films were taken immediately. The bronchoscopic impression of severe narrowing of the trachea in its middle one-third was confirmed. With these persistent findings and increasing respiratory distress of the infant, a venous angiocardiogram was carried out. There was excellent filling of the pulmonary arteries, left ventricle, and the aorta with its branches. The innominate artery and the left common carotid artery arose from a short common trunk; this vessel came off the aortic arch to the left of the midline. The innominate artery passed upwards and to the right in a course which carried it across the trachea (Fig. 3).

At surgery the angiographic findings were confirmed. The common vessel was approximately 1 cm. in length, and the

innominate artery passing to the right was causing severe tracheal compression. When these vessels had been freed of surrounding tissue, it was possible to retract them anteriorly, thus completely relieving the tracheal compression. Silk sutures were utilized to maintain fixation, the sutures passing through the adventitia of the innominate artery, the common vessel, and the right carotid artery. Two such sutures were also placed through the adventitia of the aortic arch. These sutures were passed directly through the sternum with a cutting needle and tied on the anterior surface of the sternum. The infant experienced rapid relief of his respiratory symptoms. He has been perfectly well since surgery with no recurrence of respiratory distress or infection.

DISCUSSION

There have been several excellent descriptions of the embryological changes resulting in arch anomalies, including Riker's review.[1] The following list includes the reported and theoretically possible abnormalities as devised by Edwards.[2]

1. Double aortic arch with left ductus arteriosus and left ascending aorta.
   (a) Right aortic arch with left ductus and left ascending aorta.
2. Double aortic arch with right ductus.
   (a) Left aortic arch with right ductus and right descending aorta.
   (b) Right aortic arch with right ductus and right descending aorta.
3. Double aortic arch, left ductus and right descending aorta. (Case 1)
   (a) Right aortic arch with left ductus and right descending aorta.
4. Double aortic arch with right ductus and left descending aorta.
5. Anomalous right subclavian artery (dysphagia lusoria).
6. Anomalous innominate artery. (Case 2)
7. Anomalous left carotid artery.
8. Anomalous left pulmonary artery.

The multiplicity of deformities as outlined above makes obvious the necessity for special studies to determine precise diagnosis. However, it should be emphasized that the clinical symptoms are fairly typical and their recognition should lead to the proper studies. The type and severity of signs depend upon the degree of encroachment on the trachea and esophagus, with tracheal involvement usually presenting more serious symptoms. Noisy respirations accompanied by stridor, inspiratory or expiratory or both, often occur shortly after birth. A brassy cough is frequently present, and these infants may develop repeated respiratory tract infections. Stridor is observed in some instances only when the child cries or exerts himself, and some intercostal and suprasternal retractions may be noticed. At a somewhat later age, often at the time solid foods are introduced into the diet, dysphagia may appear. A helpful observation is that flexion of the neck usually increases the respiratory difficulty and extension of the head improves it. These babies will often adopt this position and sleep more comfortably with the head extended. Cyanosis is not a prominent finding but may occur during feedings with attendant choking spells or during the course of an associated respiratory infection. Other conditions occurring during this period which must be considered

Fig. 3—Case 2. Left-sided filling phase of venous angiogram. Arrow indicates point of origin of the common vessel arising from the aortic arch. Innominate artery passes to the right and upwards across the trachea.

are: congenital laryngeal stridor, congenital webbing of the larynx, choanal atresia, tracheomalacia, tetany, foreign body, tracheoesophageal fistula without esophageal atresia, and infectious processes such as laryngotracheobronchitis.

If a vascular ring anomaly is suspected, roentgenographic studies are necessary. For detailed descriptions of the x-ray findings in these conditions, Neuhauser has published some excellent reports.[3] Anteroposterior and lateral plain films may reveal some obstructive emphysema and tracheal narrowing or displacement. An esophagram using barium must be obtained. By withholding a feeding, the infant will usually take the barium mixture sufficiently well to insure good esophageal filling. It is sometimes necessary to use a thin paste and introduce it via a small catheter. Films should be obtained in the anteroposterior and lateral views for a more detailed study at leisure. Tracheograms may be helpful, particularly in cases where the esophagram is not diagnostic, but should be undertaken with caution since many of these infants are already having breathing difficulties or have tracheobronchitis. Retrograde aortography has been utilized in cases to clarify a diagnosis but is usually not necessary. We have found venous angiocardiograms helpful in these cases; the diagnosis in Case 2 was made by this method. These studies are important, not only to establish the diagnosis but also as an aid to the surgeon in his approach.

Surgical intervention is not without dangers in these infants. Mortality figures as high as 30 per cent have been reported in those with a double arch anomaly. Those in whom the ring is completed by a ligamentum arteriosum usually have less severe symptoms, and the operative mortality is reduced. Patients with an anomalous right subclavian artery rarely have to be operated upon unless the vessel is so taut that it produces dysphagia. It is then a relatively simple procedure to divide the artery close to its origin. In the cases of anomalous innominate and left carotid arteries where the vessels arise away from their usual point of origin and cross the trachea to assume their normal course, the surgeon must free the vessel and, if possible, suture the adventitia to the sternum. Anomalous left pulmonary artery is an unusual condition in which the artery arises from the main pulmonary trunk to the right of the midline and circles behind the trachea but in front of the esophagus. Obstructive emphysema has been reported to be a prominent finding in this condition, with more involvement of the right side.

During periods of respiratory distress in these infants prior to surgery, infections should be treated adequately and early with appropriate antibiotics. If the infant becomes severely ill, cool, moist air should be utilized; proper positioning to ease respiratory distress should be effected; and constant nursing care should be instituted.

SUMMARY

Two cases of vascular ring anomalies corrected surgically are reported. The importance of considering these anomalies in the differential diagnosis of respiratory distress in infants is stressed. Esophagrams are considered the most important diagnostic aid in directing attention to these anomalies. Venous angiocardiography is an important diagnostic tool, and in one case an accurate preoperative diagnosis was established by this procedure when other methods had failed.

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REFERENCES

1. Riker, W. L.: Anomalies of the aortic arch and their treatment, Ped. Clin. N. America (Feb) 1954, pp. 181–195.
2. Edwards, J. E.: Congenital malformations of the heart and great vessels, Pathology of the Heart, Springfield, Ill., Charles C. Thomas, 1953.
3. Neuhauser, E. B. D.: The roentgen diagnosis of double aortic arch and other anomalies of the great vessels, Am. J. Roentgenol. 56:1–12 (July) 1946.

See also:

Apley, J.: The infant with stridor; a follow-up survey of 80 cases, Arch. Dis. Childhood 28:423–435 (Dec) 1953.

Gross, R. E., and Neuhauser, E. B. D.: Compression of the trachea by an anomalous innominate artery; operation for its relief, Am. J. Dis. Child. 75:570–574 (Apr) 1948.

Gross, R. E.: Surgery of Infancy and Childhood, Philadelphia, Saunders, 1953.

OFFICIAL PUBLICATION OF CONSTITUTIONAL AMENDMENTS

introduced at the May 1962 session of the House of Delegates for action by the May 1963 House of Delegates appears on page 54 of this issue of the *Wisconsin Medical Journal.*

CASE REPORT

Torsion of the Gallbladder

By JOHN T. SULLIVAN, JR., M. D., F.A.C.S. and KEITH B. APPLEBY, M. D.

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IT IS estimated that about 4 per cent of humans have a congenital "floating" gallbladder.[1,2] This anatomical malposition may be one of two types. The first consists of a gallbladder completely surrounded by peritoneum and attached to the undersurface of the right lobe of the liver by a pseudomesentery which extends along the entire length of the cystic duct only. The second type has a similar attachment to the liver, but it extends from the cystic duct to the fundus of the gallbladder (Fig. 1). Such an anatomical relationship can lend itself to acute torsion. This condition was first reported in the American literature by Wendel[3] in 1898.

Etiology, Incidence, Mortality, and Symptomatology. The precise cause producing torsion of a "floating" gallbladder is unknown. Hyperperistalsis of the colon has been considered a factor[4,5] as well as gastric hyperactivity.[6] The torsion has been found more commonly in the counter-clockwise direction.[5] Flannery and Caster[6] found the average age to be between 55 and 75 years and the female-to-male ratio 2:1. The extremes in age reported have been 5 years[7] and 93 years.[6] Since this is a congenital anomaly and stones (rarely present) are not a primary factor in acute volvulus, it is surprising that so few cases are found in the younger age group.

Reported mortality quite naturally is related to the delay or absence of cholecystectomy and ranged from 16 per cent[8] to 4 per cent in 1956.[6] Rupture and resulting severe peritonitis usually indicate delay in diagnosis and treatment with a correspondingly higher mortality. This is more apt to occur when a conservative medical regimen is followed in the management of acute

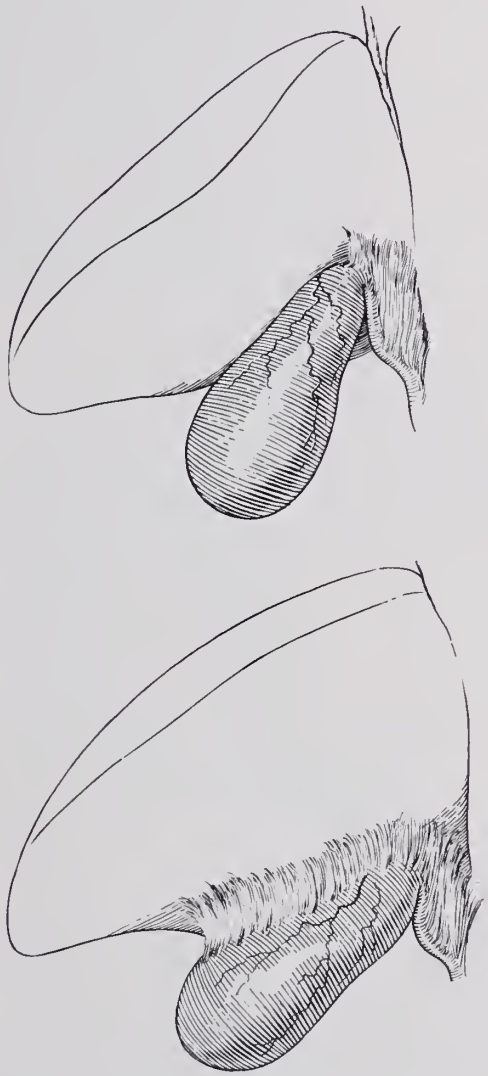

Fig. 1—(Upper) Illustration of a typical congenital "floating" or "wandering" gallbladder. Its sole attachment to the liver is by a pseudomesentery extending along the cystic duct only, thus permitting torsion, usually in the counter-clockwise direction. Gangrene, rupture and fatal peritonitis will result unless corrected by early surgical intervention. (Lower) A second type of congenital "suspended" gallbladder in which the pseudomesentery extends from the fundus along the entire cystic duct. Although "floating" such a gallbladder is obviously more restricted in its "wandering."

From the Departments of Surgery, Deaconess Hospital and Marquette University School of Medicine, Milwaukee.

Illustrations by Robert H. Albertin, B. F. A., M. A., Section on Medical Illustration, Division of Surgery, Marquette University School of Medicine.

Submitted for publication August 28, 1962.

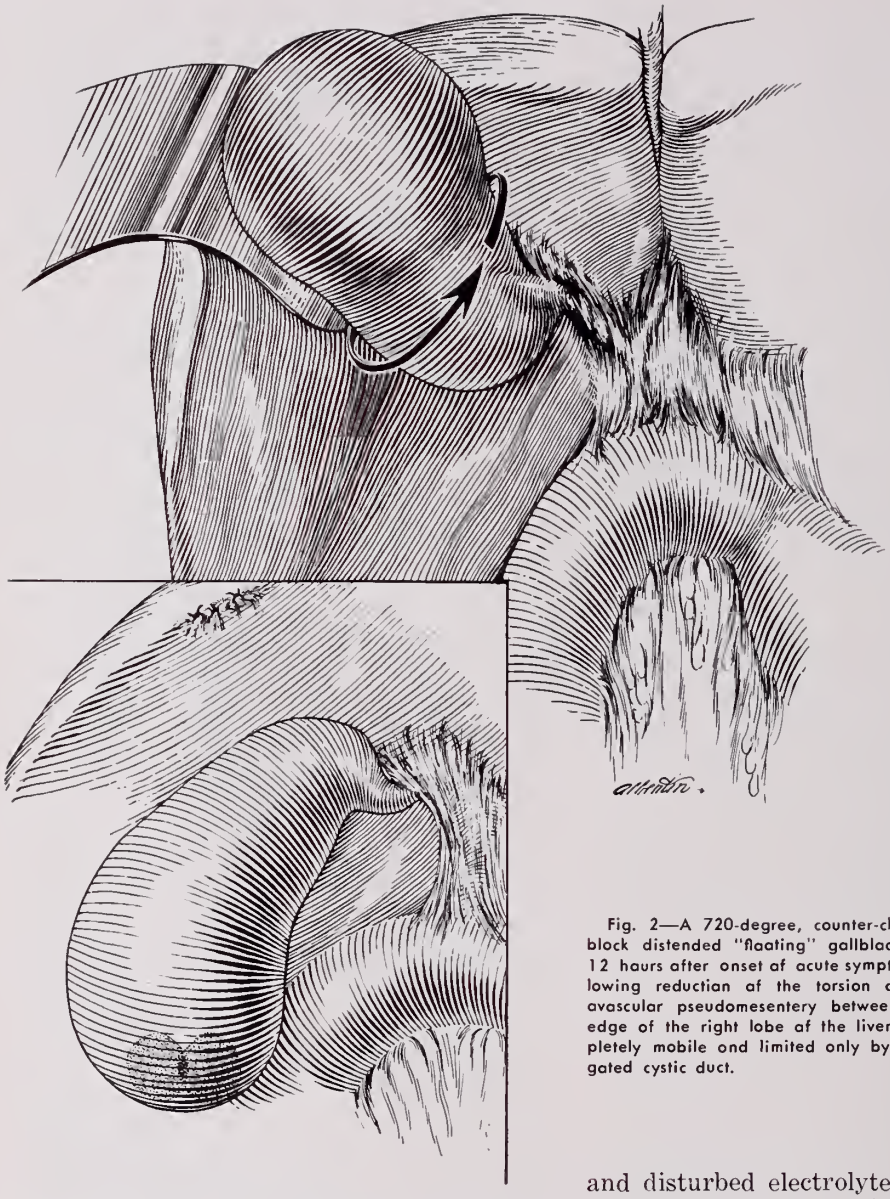

Fig. 2—A 720-degree, counter-clockwise torsion of a blue-block distended "floating" gallbladder is an 84-year female, 12 hours after onset of acute symptoms (see text). (Inset) Following reduction of the torsion and severance of the thin avascular pseudomesentery between the cystic duct and the edge of the right lobe of the liver, the gallbladder was completely mobile and limited only by its attachment to an elongated cystic duct.

cholecystitis. A 48-hour delay in cholecystectomy in such cases will result in a fatality according to Short and Paul[5] and Case.[9]

Cardinal symptoms of acute volvulus of the gallbladder are usually found in a thin elderly female without a history of previous gallbladder symptoms. The onset is typically quite sudden without prodromal indigestion or malaise and consists chiefly of severe steady right upper quadrant pain followed by nausea, emesis, and frequently a palpable tender mass. Jaundice is not present. Elevated white blood cell count, dehydration, and disturbed electrolyte balance are found in relation to the duration of the symptoms. X-ray studies of the abdomen may present a clue to the diagnosis if gallstones are present since they frequently shift considerably when films are taken with the patient in various positions. This may appear at first to be a very large gallbladder but is usually due to the excessive mobility of the "wandering" organ.

Case Report. An 84-year white female, weighing 78 pounds (35.4 Kg.), was admitted to the hospital on May 24, 1960, with right upper quadrant constant, non-

radiating pain since the morning of admission. There was nausea but no emesis. Past history was noncontributory. The patient's temperature was 99 F. (37.2 C.) orally, pulse 92, respirations 24, and blood pressure 158/60. Physical examination was essentially negative except for the abdomen which was scaphoid and presented moderate muscle guarding about the right side. Peristaltic sounds were hyperactive and somewhat high pitched. Severe tenderness was present in the right upper quadrant with an ovoid, soft, smooth mass approximately 10 × 4 cm. located about 2.5 cm. below the right costal margin. The liver was not palpable. Laboratory studies were essentially normal except for a white blood cell count of 10,450 with 85% segmented neutrophils. Abdominal x-ray films revealed the presence of two "marble-sized" gallstones which showed considerable mobility; slight ileus was noted, and the liver and spleen were not enlarged. A diagnosis of acute cholecystitis with possible empyema was made and the patient was prepared for immediate laparotomy.

Surgery was performed 12 hours following onset of symptoms and 5 hours after the patient's admission to the hospital. Beneath and above the right lobe of the liver a thin-walled, smooth, bluish-black, distended gallbladder approximately 13 × 6 cm. was found. It had rotated counter-clockwise 720 degrees (two complete turns) and was easily reduced (Fig. 2). The gallbladder was not adherent to the liver; its elongated, tortuous, narrow cystic duct had a thin avascular mesenteric-like attachment to the edge of the right lobe of the liver. This pseudomesentery measured about 2.5 cm. in length and 1.5 cm. in its attachment to the cystic duct (Fig. 2, inset). The common duct was essentially normal and a routine cholecystectomy was performed. The patient made an uneventful recovery.

The pathological report was chronic cholecystitis with cholelithiasis and superimposed acute hemorrhagic cholecystitis.

Treatment. The essence of successful treatment of acute torsion of the gallbladder is a prompt laparotomy. Although a brief conservative medical management of acute cholecystitis may be acceptable to many surgeons, such a delay has little to offer when dealing with acute torsion. The findings of an acute abdomen in a patient presenting a sudden onset, a palpable right upper quadrant mass with severe tenderness, pain, nausea, emesis and, occasionally, very mobile calculi in the gallbladder region, should motivate the surgeon to perform an abdominal exploration without delay. Once the situation is ascertained, cholecystectomy is greatly simplified technically, since the gallbladder is relatively unattached. Because of the rapid necrotic factor due to torsion, *cholecystostomy* is never justified.[10] However, the usual technical precautions relative to gallbladder surgery must not be omitted since other abnormal anatomy in this region may be present.[11]

Summary. A congenital "floating" gallbladder occurs in about 4 per cent of the population. Acute volvulus of a floating gallbladder was first reported in 1898 and is a relatively uncommon condition. Cases reported are usually in elderly, thin women without a history of previous gallbladder disease and present symptoms of sudden acute onset of right upper quadrant tender mass and without jaundice. Signs and symptoms are usually diagnosed as acute cholecystitis. Conservative medical management results in a high mortality rate because of rapid gangrene and rupture of the gallbladder due to complete absence of blood supply produced by the torsion. A case of acute volvulus of a "floating" gallbladder in an 84-year female is presented.

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REFERENCES

1. Bockus, H. L.: Gastroenterology, Vol. III, W. B. Saunders Company, Philadelphia, 1946, pp. 461–463.
2. Brewer, George E.: Anatomy of gallbladder and bile ducts, Ann. Surg. 29:721–730 (Jan–June) 1899.
3. Wendel, A. V.: Torsion of gallbladder, Ann. Surg. 27: 199–202 (Jan–June) 1898.
4. Meeker, W. R., and Lisenby, J. O.: Ptosis and torsion of gallbladder, South. M. J. 25:609–614 (June) 1932.
5. Short, A. R., and Paul, R. G.: Torsion of gallbladder, Brit. J. Surg. 22:301–309 (Oct) 1934.
6. Flannery, M. G., and Caster, M. P.: Collective reviews; congenital abnormalities of gallbladder; 101 cases, Internat. Abstr. Surg. 103:439–457, 1956, in Surg. Gynec. Obst. (Nov) 1956.
7. Cuervo, S., and Cuervo, T.: Proposito de dos casos de volvulo biliar en dos ninos de einco y once anos de edad respectivamente, Arch. Soc. Estud. Clin. (Habana) 33:295–305 (May) 1939.
8. Arthur, H. R.: Acute torsion of gallbladder, Brit. M. J., 2:265–266 (Aug 7) 1937.
9. Case, T. C.: Acute torsion of gallbladder, Am. J. Surg. 82:749–753 (Dec) 1951.
10. Sullivan, John T., Jr.: Cholecystostomy: an outmoded procedure? Wisconsin Med. J. 59:733–734 (Dec) 1960.
11. Sullivan, John T., Jr.: Relation of eholecystectomy complications to inadequate exposure and technical errors, Illinois M. J. 114:156–159 (Oct) 1958.

CLINICOPATHOLOGIC CONFERENCE

Sponsored by Section on Pathology
State Medical Society of Wisconsin

Guest Editor: JAMES L. JAECK, M. D.
Sheboygan, Wisconsin

CASE PRESENTATION*

Dr. Joseph F. Kovacic: This patient is a 12-year-old boy who was admitted to the hospital with the complaint of intermittent crampy abdominal pain, moderately severe and generalized. The family physician had seen the patient at his home two days prior to admission. At that time the patient also had diarrhea, nausea, some frequency, occasional nocturia, but no vomiting. He had a subnormal temperature but no chills. Physical examination revealed no localized tenderness, no muscle spasm, no rebound tenderness, no palpable masses, but there were borborygmic sounds over the abdomen. The physician felt the boy had an enterocolitis, or stomach flu, left some medication, and told the parents to call him if the boy was not better in 48 hours.

After 48 hours there had been no change in his condition, and the physician advised hospitalization for observation and diagnostic studies. Physical examination on admission to the hospital revealed a mildly dehydrated 12-year-old boy with a temperature of 98.8 F., pulse 96, and respirations 24 per minute. There was still generalized abdominal tenderness, no rebound tenderness, and no muscle spasm. Bowel sounds were still prominent. The liver and spleen were not palpable and there were no palpable tumor masses. While the abdomen was being examined, the patient had a strong urge to void. Genitalia were normal. There were no hernias.

During the first few days in the hospital, his symptoms remained the same and no localizing signs appeared. Treatment was symptomatic and intravenous fluids.

On the fifth hospital day it was noted that he was developing a swelling in the lower abdomen, giving him a "pot belly" appearance. There seemed to be a cystic, nontender, intra-abdominal mass occupying the entire lower half of the abdomen. On rectal examination the prostate and bladder seemed to be separate from the mass, and on bimanual examination the mass seemed to be out of the pelvis. It again was not tender and seemed to contain fluid.

X-ray films of the abdomen that same day, with the patient in the upright position, revealed no soft tissue mass in the lower abdomen, no displacement of the colon, and no calcifications. On the following day an excretory urogram revealed somewhat delayed function on the right with slight dilatation of the pelvis and calyces of the right kidney and of the right ureter. It also revealed a soft tissue mass in the pelvis extending posteriorly and narrowing the rectum in the lateral projection. It extended to within 1.0 cm. of the sacrum and was above the brim of the pelvis. It was thought to be separate from the bladder but impinging upon it from above. The mass appeared to obstruct the right ureter. It did not appear to arise from the sacrum. Chest x-ray revealed normal lungs, heart, and thorax.

Laboratory studies revealed a hemoglobin level of 14.6 gm. per 100 ml.; hematocrit reading of 39.5 vol. %; white blood cell count of 11,500 per cu. mm. with a differential count of 78 segmented forms, 4 stab forms, 2 eosinophils, 11 lymphocytes, and 5 monocytes. Urinalysis on several occasions revealed specific gravity from 1.014 to 1.028, no albumin, sugar on one occasion (thought to be due to parenteral fluids), no acetone, and no microscopic blood or pus; serology negative; blood sugar on one occasion 112 mg. per 100 ml.; stool culture revealed a heavy growth of Escherichia coli and Proteus.

His hospital course was fairly uneventful. His temperature ranged from 98.6 F. to 101.0 F. the first 14 days and only once (on the first postoperative day) rose to 102.0 F., and then tapered off to normal. His stools were soft, yellowish-green, occasionally semi-fluid with an offensive odor. Bowel movements varied from two to four a day. At no time was there any blood or occult blood in the stools. One stool examination for ova and parasites was negative. An exploratory laparotomy was performed

* From St. Nicholas Hospital, Sheboygan.

after two weeks in the hospital. Postoperative course was uneventful and he was discharged from the hospital a week later.

DISCUSSION

Dr. James L. Jaeck: This discussion will be an open forum for staff participation rather than having the usual moderator or guest discussant, as in most clinicopathologic conferences. Doctor Tompsett will discuss the x-ray films.

Dr. Arthur C. Tompsett: I would like to correct one ambiguous statement in the protocol. "The mass came to within about 1.0 cm. of the sacrum" should have read "and extended above the brim of the pelvis." The excretory urogram showed dilatation of the right kidney, calyces, pelvis, and ureter. There was an indefinite soft tissue density in the pelvis. There was a little air in the small and large intestine and some in the stomach, but they were not greatly dilated. This probably represented a loop of small bowel. The lateral projection showed this extension into the pelvis. Air can be seen in the rectum, and I felt that this density was probably a soft tissue mass extending *backward* and displacing the rectum and not involving the sacrum. The dye-filled bladder was seen in this area on the original films. The bladder was displaced downward a little bit. I could make out no calcification anywhere in any of the films. The mass seemed to be pretty much in the midline.

Doctor Jaeck: Did you make a definite diagnosis on the basis of the x-ray studies?

Doctor Tompsett: No, I made no single definitive diagnosis. The things that occurred to me were mesenteric cyst and retroperitoneal tumors of various kinds. The fact that I found no evidence of calcium or calcification anywhere made me less apt to think that this was a teratoma.

Dr. Robert M. Senty: Is the information in the protocol correct in stating that this

Fig. 1—Excretory urogram showing the dilated right ureter and the soft tissue mass in the pelvis.

Fig. 2—Lateral projection showing the air-filled rectum outlining the posterior surface of the soft tissue mass near the sacrum.

"pelvic tumor mass" was not present at the time of the first or upright film of the abdomen?

Doctor Tompsett: This was simply a survey abdominal film and no colon study or barium enema was done concurrently. I could see no soft tissue mass in the abdomen. In retrospect there probably was something visible in the pelvis which showed up much better on the urogram.

Doctor Jaeck: Doctor Weber, what is your opinion about this mass?

Dr. Carl J. Weber: I don't know specifically what kind of a tumor mass this might be, but from its location deep in the abdomen and pelvis, I would suggest a possible dilatation of the rectum or a megacolon. I would also think of a benign cyst of some type.

Doctor Jaeck: Doctor Senty, would you like to comment?

Doctor Senty: The genitalia apparently were normal. I would like to ask whether the testes were both present in the scrotum of this patient?

Doctor Kovacic: Yes, they were.

Doctor Jaeck: Doctor Michael, would you care to comment about the case?

Dr. James D. Michael: Doctor Kovacic, was this mass freely movable from side to side?

Doctor Kovacic: Doctor Nause would probably like to answer that question since he was the surgeon in this case.

Dr. Frederick P. Nause: I saw the patient for the first time on his fourth hospital day. The next day I became somewhat disturbed because his temperature had not decreased. While examining him in bed, I noticed for the first time the abdominal mass. My first thought was that he had a full bladder because the mass was exactly in the midline and suprapubic in location. We asked him to void, which he did without difficulty, but the mass was still present. I then performed a rectal examination and at that point, in answer to your question, this mass seemed to be so large that it filled the whole pelvic cavity and was immobile or at least not ballotable. It seemed to me that it filled the pelvis and then sort of brimmed over into the lower abdominal cavity. There was definite compression or constriction of the rectum by the mass with bulging above the point of constriction, which would be comparable in size to my hand and extending nearly to the umbilicus. From the bedside I immediately went down to take a look at the x-ray films. The only one available was the upright film, and it was apparent that the colon was filled with stool. At that point I reasoned that perhaps he was having diarrhea because of a fecal impaction and that this was impinging upon the rectum.

The next day the excretory urogram films, which you have just seen, were available and the impression of abdominal or pelvic mass was corroborated. My impressions were about the same as Doctor Tompsett's, but I believe I favored a retroperitoneal cyst as my preoperative diagnosis. I had the impression that I was feeling a ballotable tumor mass, at least that portion above the pelvic brim, and that it contained fluid and was a cystic mass.

Doctor Michael: Couldn't this possibly be a urachal cyst in the remnant of that portion of the genitourinary tract? The fact that it seemed to expand so rapidly and attain such size made me wonder if indeed it did not contain urine. My second choice of diagnosis would be a mucous-forming cyst of the enteric system, a lesion on the order of a mucocele. I am presuming that this is not a solid tumor. I do not believe I would consider neurogenic tumors arising from the sacrum, but I would entertain the possibility that this could be a mesenteric cyst. I will, however, cast my vote for a urachal cyst.

Doctor Tompsett: I would like to make one comment on the lateral projection of these films. I haven't seen many urachal cysts, but I would anticipate that they should be anterior in position. I would be surprised to see one extend backward down into the pelvis. That is one reason why I put that far down on my list of diagnostic possibilities.

Dr. Donald M. Rowe: What is the past history of this boy's bowel habits?

Doctor Kovacic: His bowel habits were regular up to the time of his present illness and entry into this hospital.

Doctor Rowe: On examination at home, where was his pain localized?

Doctor Kovacic: The pain in the abdomen was never localized and it was generalized in type throughout the entire abdomen. In fact, it seemed typical for gastroenteritis, or so-called stomach flu.

Doctor Rowe: My diagnosis would be perforated appendix with abscess.

Doctor Jaeck: We now have one diagnosis unrelated to neoplasm. Was a urologist consulted?

Doctor Kovacic: Yes, Doctor Graf saw this boy in consultation.

Doctor Jaeck: Doctor Graf, can you defend your consultation report?

Dr. Chris A. Graf: With the findings of some obstruction in the right genitourinary tract, cystoscopy and retrograde films were considered. However, on physical examination the prostate and bladder were completely separate from this mass, and it appeared that the obstructive signs were due to extrinsic pressure. Since an exploratory laparotomy was planned, I saw no reason to do any further diagnostic studies. I definitely felt that the mass was outside of the genitourinary tract.

Dr. Harris A. Weisse: Doctor Jaeck, a ruptured appendix with abscess has already been mentioned by Doctor Rowe. Could this not be a ruptured diverticulum in either the large or small intestine, particularly a ruptured Meckel's diverticulum?

Doctor Jaeck: I would like to ask those that offered these latter two diagnoses, namely, ruptured appendix with abscess and ruptured Meckel's diverticulum, on what basis they made this diagnosis?

Doctor Rowe: I would base my diagnosis, first of all, on the history of his abdominal pain. I further think that it is one of the things which should be considered in a child in this age group. In my experience a low grade fever with persistent diarrhea sometimes indicates abscess formation somewhere in the gastrointestinal tract.

Doctor Jaeck: How would you explain this apparent tumefaction in the lower abdomen and pelvis?

Doctor Rowe: I would think that it could be an accumulation of purulent material or possibly even feces.

Doctor Weisse: Pelvic abscess secondary to a ruptured Meckel's diverticulum would be my explanation for the mass.

Doctor Kovacic: Would one of the surgeons state whether it is common to find a ruptured diverticulum in a boy 12 years of age?

Doctor Nause: Meckel's diverticulum possibly, others no.

Dr. John E. Martineau: The diagnosis of mesenteric cyst has been made. No mention has been made of omental cysts. Sometimes these are low in the pelvis and might be silent for a number of years until they cause pressure and/or obstruction.

Doctor Jaeck: An incidental finding at autopsy in the last six weeks was an omental tumor that was partially cystic weighing 1100.0 gm. that was down in the pelvic cavity by gravity. It was freely movable. It was definitely in the omentum and not attached to anything. It turned out to be a lipoma with cystic degeneration. I would agree, Doctor Martineau, that the omentum as well as the mesentery can be the site of such a lesion. I heard someone mention echinococcus cyst. Was there any history of travel or had this boy ever been in Iceland or elsewhere, Doctor Kovacic?

Doctor Kovacic: No this boy was at home at all times.

Dr. James Weygandt: Did he have a dog?

Doctor Kovacic: I do not know.

Doctor Jaeck: The only echinococcus disease I have ever seen was when I was stationed in Iceland in 1941 and 1942. There was one entire hospital in Iceland with nothing but echinococcus patients. To my knowledge, most of the echinococcus pathology in that hospital had to do with liver disease. I see no reason why an echinococcus cyst of some other organ or tissue could not be possible. Maybe other parasitic cyst formation should also be a consideration.

Doctor Nause: We certainly didn't expect what we found on exploratory laparotomy. Doctor Weisse and Doctor Rowe are apparently a lot smarter than we were. We opened the abdomen and there were masses and coils of adherent small bowel. There was not a drop of pus in the abdomen or pelvic cavity anywhere. The entire "tumor mass" was a mass of adherent loops of small bowel covered by fibrinous exudate. When we finally got down through all of this, we found a ruptured appendix. There was no free pus of any kind or any other abnormality of the appendix or cecum. The fibrinous adherent loops of small bowel were not dilated and there was no evidence of intestinal obstruction that we could make out.

Doctor Jaeck: Doctor Tompsett, will you tell us how you explain this on x-ray studies?

Doctor Tompsett: I am as puzzled as the surgeon was. Perhaps I inadvertently gave

a little hint (in retrospect) in that on the urogram you can see a loop or two of small intestine, which looks a little bit distended, but there is no "ladder-effect" or any other x-ray sign of ileus or intestinal obstruction. Furthermore, this is not an uncommon finding on an abdominal film in which infection of any kind is present in the abdomen. So all I can say is that I found no evidence of intestinal obstruction and neither did the surgeon. I was as surprised at the diagnosis as anyone else.

Doctor Jaeck: Doctor Nause, I don't believe you told us yet whether you found anything retroperitoneally.

Doctor Nause: Yes, I did state that there was no other abnormality.

Doctor Rowe: One more question. No one has mentioned whether this boy had antibiotic therapy at home or in the hospital.

Doctor Kovacic: There was no antibiotic therapy. He was given Kaopectate at home.

Doctor Jaeck: Doctor Dick, as another pathologist here, would you care to comment about this case or any similar ones?

Dr. Herman J. Dick: The only one similar that I can think of happened in my own family. My aunt was thought to have an ovarian cyst. At operation, she had a large uterine fibroid behind which her appendix was ruptured and there was a periappendiceal abscess. This, clinically, gave a similar ballotable cystic tumor mass in the abdomen. No ovarian cyst was found at surgery. I also can remember a case of a young boy who was not very acutely ill and who, at operation, had a ruptured appendix, but this had been complicated by a Clostridium Welchii infection, so that he actually had a gas gangrene of the appendix and cecum. Clinically this also had cystic qualities.

Doctor Jaeck: Are there any other comments or discussion about this case?

Doctor Nause: The thing that impressed all of us who had anything to do with this case was that this child never looked sick at all. There was no sign that he had any inflammatory process except for the mild febrile response as noted in the protocol. I think this is perhaps one of the reasons no one entertained the diagnosis of appendicitis.

Doctor Jaeck: I can remember one recent unusual specimen. This was a case of a ruptured appendix in an inguinal hernia sac. As you might imagine, this might present a slightly bizarre clinical picture. I think all of us are acquainted with some of the exotic and abnormal positions of the appendix, some of them associated with malrotations and congenital or developmental anomalies. Has anyone else had any unusual experience with the simple diagnosis of acute appendicitis?

Doctor Rowe: Several years ago we saw a 20-year-old mentally deficient boy who had been seen by one of the doctors on this staff two weeks previously. He came into the office, bent over with pain, with his father who was even less intelligent than the boy. He had a fluctuant abscess in the right groin. Actually, it looked more femoral than inguinal in location. We sent him to the hospital where we found a subcutaneous abscess which extended almost to the umbilicus. It drained about two quarts of pus. The abscess was due to a ruptured appendix. He stayed in the hospital 48 hours and went home against advice. We never saw him again. As far as I know, he is all right.

Dr. Richard Windsor: I think that at a meeting of surgeons you could get a hundred or more unusual experiences or mistaken diagnoses for the common entity we know as acute appendicitis. I think that any presenting lower abdominal mass or tumor in the midline, pelvis, or right lower quadrant of the abdomen might be appendicitis.

Doctor Jaeck: I asked two or three of the staff surgeons to write down the things which in their experience should be considered in the differential diagnosis of acute appendicitis. This list includes the following: mesenteric lymphadenitis, right pyelonephritis, ureteral calculus, salpingitis, ovarian tumor with twisted pedicle, ruptured ovarian cyst, ruptured ovarian follicle, gastroenteritis, bowel obstruction, pneumonia, perforation of cecal carcinoma, early ectopic pregnancy, radiculitis, Richter's hernia, inflammation or perforation of Meckel's diverticulum, regional enteritis, mesenteric cyst, intussusception, diverticulitis with or without rupture, cholecystitis, ruptured duodenal ulcer, "idiopathic peritonitis of children". The lesson is obvious. Acute appendicitis is not always an easy diagnosis. The pathologic diagnosis on the specimen removed at exploratory laparotomy, in this case, was acute suppurative appendicitis with perforation but without gangrene.

Editor
H. F. HARDMAN, M. D., Marquette University

COMMENTS ON TREATMENT

Treatment of Poisoning Due to Alkylphosphate Cholinesterase Inhibitors

By JAMES L. WAY, Ph. D.
Milwaukee, Wisconsin

THE ALKYLPHOSPHATES are a group of extremely toxic organic phosphorus compounds which are generally classified as organic esters of phosphoric and phosphonic acids. Their physiologic and toxic effects are attributed predominantly to the inhibition of the enzyme, acetylcholinesterase. Poisoning from these compounds may occur following accidental exposure to insecticides, e.g., parathion and tetraethylpyrophosphate; chemical warfare gases, e.g., sarin and tabun; and after administration of excessive amounts in the management of abdominal distention,[1] glaucoma[2] and myasthenia gravis.[3]

Signs and symptoms of sarin (nerve gas) intoxication have been studied quite extensively in man.[4] In general, similar pharmacological effects are observed with the other alkylphosphates, e.g., diisopropylfluorophosphate (DFP), tetraethylpyrophosphate (TEPP), Parathion, Schradan (OMPA) and Systox. Since the mechanism of action of the alkylphosphates is ascribed mainly to the inhibition of acetylcholinesterase, thereby preventing the rapid hydrolysis of acetylcholine, the pharmacological effects observed should be a more prolonged and intensified action of acetylcholine at several sites, i.e., at the central nervous system, and at the ganglionic (nicotinic), neuromuscular (nicotinic) and postganglionic (muscarinic) junctional sites. Accumulation of acetylcholine at the various postganglionic sites due to alkylphosphate administration are manifested as follows: (1) secretory glands—increased sweating, lacrimation, salivation and bronchial secretion; (2) eye—miosis and blurring of vision; (3) heart—bradycardia; (4) bladder—frequency and involuntary micturition; (5) bronchial tree—bronchoconstriction and dyspnea; and (5) gastrointestinal tract—anorexia, nausea, vomiting, abdominal cramps, diarrhea, and involuntary defecation. Some of the effects of the alkylphosphates which are referable to the central nervous system are giddiness, anxiety, emotional lability, headache, tremor, ataxia, coma, convulsions and depression of respiratory and circulatory centers. Weakness and fasciculations are two of the predominant skeletal neuromuscular effects.

The following factors have been shown to be operative in contributing to the cause of death in individuals poisoned by these cholinesterase inhibitors: (1) Central nervous system—paralysis of the respiratory and circulatory centers, and convulsive manifestations. (2) Respiratory system—neuromuscular blockade with early involvement of respiratory muscles (diaphragm, intercostal and accessory muscles). Bronchoconstriction usually is not an important factor in causing death, provided the additional effects of obstruction of the bronchi by the heavy secretions of saliva and mucus are avoided by postural drainage. (3) Circulatory system—bradycardia, decreased cardiac output and peripheral vascular effects. Death appears to be primarily asphyxial in some instances and primarily cardiovascular in others, and in some cases, failure of both seems to coincide.

The correct treatment of alkylphosphate intoxication should include, of course, removal of the toxic agents and decontamination of the exposed surface area. In addition, therapy consists of artificial respiration, if

necessary, forced fluids, atropinization, and the administration of 1-methyl-2-aldoximinopyridinium iodide (2-PAM).

Atropine sulfate should be administered in individual doses of 2.0 to 5.0 mg. intravenously or intramuscularly, repeated at intervals of a few minutes until signs and symptoms of intoxication are markedly reduced. In severe poisoning fairly large doses of atropine may be required before evidence of atropinization appears and these effects may be only transient and persist for only 10 to 30 minutes. As much as 24 to 50 mg. of atropine have been administered daily to give maximal protection. Such doses are said to be unpleasant, but not dangerous.[4]

Recently there has been developed a number of alkylphosphate antagonists which reactivate cholinesterase inhibited by the alkylphosphates. One of these antagonists employed in the clinical treatment of various alkylphosphate intoxications is 2-PAM. This compound is administered at a dose of 0.5 to 2.0 gm. either in repeated injections or in slow intravenous infusion. It should be pointed out that the use of 2-PAM after massive doses of atropine, although an extremely valuable adjunct to atropine in the management of anticholinesterase alkylphosphate intoxication, will increase the signs of overatropinization. Of practical importance is the fact that 2-PAM as the chloride salt is now available and it has better solubility properties than the iodide salt.

Prognosis is markedly more favorable the sooner the treatment is instituted and the slower the onset of signs and symptoms of intoxication. Once the crisis is past, recovery is usually complete.

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REFERENCES

1. Grob, D., Lilienthal, J. L., Jr., and Harvey, A. M.: Administration of di-isopropyl fluorophosphate (DFP) to man; effect on intestinal motility and use in treatment of abdominal distention, Bull. Johns Hopkins Hosp. 81:245–256 (Oct) 1947.
2. Leopold, I. H., and Comroe, J. H., Jr.: Use of di-isopropyl fluorophosphate ("DFP") in treatment of glaucoma, Arch. Ophth., 36:1–16 (July) 1946.
3. Rider, J. A., Schulman, S., Richter, R. B., Moeller, H. C., and Du Bois, K. P.: Treatment of myasthenia gravis with octamethyl pyrophos-phoramide: preliminary report, J.A.M.A. 145: 967–972 (March 31) 1951.
4. Grob, D.: Manifestations and treatment of poisoning due to nerve gas and other organic phosphate anticholinesterase compounds, Arch. Int. Med. 98:221–239 (Aug) 1956.

SALMONELLOSIS

Dr. Ruby Bere of the State Laboratory of Hygiene reported the recent isolations of *Salmonella typhimurium* for stool specimens submitted from a northern Wisconsin farmer and five members of his family.

Shortly before this, salmonellosis was clinically diagnosed in sick cows on the farm and a group B salmonella was isolated from one of the cows by the Central Animal Diagnostic Laboratory. A subculture of this organism was sent to the State Laboratory of Hygiene at the request of Dr. Josef Preizler of the State Board of Health, and it was found to be *Salmonella typhimurium* also.

It is suggested that when human cases of diarrhea resembling salmonellosis occur, stool specimens should be sent in by the physician to the State Laboratory of Hygiene for isolation procedures. When a similar diarrhea is occurring in animals associated with human cases, a veterinarian should be called to examine the animals and specimens can be sent by him to the Central Animal Diagnostic Laboratory in Madison or to the Regional Animal Diagnostic Laboratory in Barron.—*Laboratory Newsletter*, Vol. 1, No. 3, October 1962, State Laboratory of Hygiene, Madison, Wis.

TREATMENT OF FROSTBITE

An Alaskan surgeon reported last fall on a method of treatment of frostbite that involves restoration of general body heat, rapid rewarming in water or a whirlpool bath when feasible, followed by daily or twice-daily whirlpool baths at body temperature. He told the 47th annual Clinical Congress of the American College of Surgeons, Oct. 2–6, 1961, that there is less tissue loss in patients treated by initial rapid rewarming, greater loss in those treated by gradual thawing and the greatest loss in those using ice and snow as a thawing agent. "No value has been demonstrated by use of vasodilators, anticoagulants, or sympathectomy," Dr. William J. Mills, Jr. of Anchorage, Alaska, said.

"Despite centuries of experience with freezing injuries little agreement has been demonstrated in this form of cold insult," Doctor Mills said. "It would appear, however, that the latitude of treatment, ranging from slow thawing in ice water or packed snow or ice, or gradual thawing at variable room temperatures, or immersion of the part in a warm water bath, might be profitably narrowed."

THE PRESIDENT'S PAGE . . .

Sincerely Yours

AS YOUR president, I have been about your work as diligently as possible. Part of my time has been spent attending meetings and programs which have given me a comprehensive survey of the structure and activities of the State Medical Society. With attendance at Council meetings, commission and committee meetings, and the House of Delegates, besides the American Medical Association and its special institutes, and interprofessional meetings, I have become aware of similar problems which exist in other fields.

It is my sincere desire that all of you avail yourselves of the services and facilities offered by the State Medical Society. Only through study and a desire to be informed can we know and understand the purposes and objectives of our medical society and join our fellow members in exerting the influence and impact of our profession on the issues of public health and preventative medicine, as well as on nonmedical affairs. We should be able to make ourselves heard in the field of legislation where it involves the patient, the doctor, and the relationship of the two. These seemingly extraneous pressures are now as important to us as strictly professional excellence and skill. Many changes have occurred because of scientific advances—many more will come at a faster pace in the future—and we must be able to retain what is good of the old, but keep pace with the new.

To further this goal, it is imperative that young and intelligent physicians interest themselves in everything pertaining to medicine. We also need more interest from the medical school faculties. It is a full time job to understand the problems of private practice and its day to day problems. A closer tie between students and physician could result in recognizing that study and research alone do not bring relief at the bedside of the patient.

Many important studies such as legislation, distribution of physicians, preschool care, and insurance are made by our society members. We should all realize its potential for the profession, and keep alert to the problems we face through our society organization.

Criticism of our medical society comes largely from members who lack knowledge of its activities and organization. I admit to entering medical society activities because I felt critical, too. The years of participation have convinced me and many others of the sound organization and the dedicated service of hundreds of State Medical Society members. Furthermore, there has been both wisdom and probably some very good luck in selecting and keeping such an outstanding staff.

One principal recommendation: For the benefit of the medical profession, we can use the services of all thoughtful and energetic society members who have constructive ideas and the persistence to implement them.

N. A. Bieg, M.D.

the WISCONSIN MEDICAL JOURNAL
Published Monthly
MARCH 1963
Vol. 62 No. 3

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Pandemic Predicament

THE phenomenal increase in the percentage of American citizens who have partial or complete protection against the cost of illness through voluntary prepayment mechanisms produces expressions of pride in private enterprise. Voluntary methods, its advocates point out, can do the job, and the public accepts them. Between 1947 and the close of 1962 the number of persons with some form of coverage climbed from 30% to 75%. And now the elderly are purchasing sickness protection at a faster rate than any other group, so that presently more than half of all persons over 65 have coverage.

The statistics that illustrate the meteoric spread of voluntary health insurance are indeed awesome, and lend substance to the roseate opinion of some that the American public, so enamored with the voluntary prepayment siren, would never shuck this pleasant arrangement for any other system of financing medical care. Yet storm warnings steadily emit from the beacons of industry, organized labor, consumer groups, legislators, and regulatory agencies, while organized medicine wallows, virtually alone, in ever more turbulent waters. The pressures for tax-supported medical care increase year by year with commensurate dissipation of professional energy in defense of the voluntary system, energy better expended in the area of public health.

The wounded clamor of purchasers of health insurance, both individuals and groups, has become a familiar sound of protest across the nation, almost as recognizable as a Bronx cheer. Physicians themselves have sometimes been overheard in like exercise when viewing their own premium statements. Basic to the issue, of course, is the principle that the cost of any commodity, including that of sickness care, must determine its price.

Too often the practicing physician considers the economic bind of medical care distribution neither any of his making nor any of his concern. In an era of unprecedented demand for his services and incidental prosperity he is apt to hold himself aloof from what he considers to be mainly a "hospital problem," and worries little about the suggestions of state control over economic policies of general hospitals.

Even worse, a few doctors, apparently encouraged by the adulation of their patients, suddenly become self anointed experts, savagely attacking their own and other prepayment organizations publicly, displaying such appalling ignorance and disregard of facts as to make suspect their own integrity.

More people demand a greater quantity of more sophisticated medical service, and its cost will probably increase along with the rising costs of all other goods and services. This is a reasonable premise and all reasonable persons accept it. But the increase cannot be run-away in character lest catastrophic corrective action is evoked, and it is squarely up to the medical profession to keep it reasonable. This means a grass roots cooperative effort of unparalleled vigor or our system will not survive.

State and national organizations point the way but effective action must take place in every county medical society. Local utilization committees, insurance advisory committees, grievance committees, public policy committees, and public relations committees must operate effectively and continuously to whatever degree is necessary to maintain enlightened control of medical care distribution and costs. Lame excuses relating to demands of patients must be unacceptable, shotgun methodology with laboratory facilities must be inexcusable, sloppy treatment with a profusion of expensive drugs must be condemned. Essentially, it is urgent that every physician involve himself in the problems of costs, not only in reasonably pricing his own services, but in helping to keep the total cost minimal while rendering logical, efficient, high quality medical care.

It is the physician who orders hospitalization, laboratory tests, drugs, consultation, and release from confinement. Concerted action can defeat the senseless occupation of the increasing number of available hospital beds, and the relatively few who abuse can be brought pari passu with the economic facts of life.—D. N. G.

Off The Floor For '64

WITH A SCANT year and a half before the next presidential election, the major political parties are already girding their loins and flexing their muscles for their quadrennial confrontation. Leading contenders for nomination have plotted their strategy and have already made their opening gambits. Fortunately, the political amateurs too are marshalling their forces, and thereby resounds the happiest note of the coming campaign.

Political amateurs—citizens whose involvement in politics is limited to the election of a specific candidate for reasons of principle rather than party discipline—have played an increasingly significant role in recent presidential elections. Because they are not subject to the constraint of patronage, or the lack of it, they are the bane of the machine, having rendered unpredictable what was previously established political pattern. But while the political amateur has earned the grudging respect of the working politician, he has also merited his contempt for the fact that the political amateur "crawls out of the woodwork once every four years."

As the effectiveness of political amateurism grows, so does the realization that political involvement cannot be a crisis activity. To be worthwhile in the presidential and important congressional elections, political leverage must be sensibly applied. It must be organized and used with the proficiency that characterizes the professional politician.

Happily for doctors, the American Medical Political Action Committee is already in high gear with a training program for political effectiveness in 1964. Designed especially for doctors who are prone to moan about the sad straits of national and local affairs, the AMPAC program emphasizes that financial contributions are not enough to elect candidates. It points out that the experience of the 1962 congressional elections demonstrated that "help to candidates was successful in direct proportion to the efficiency of our candidate support organizations. Good organization got results in case after case; poorly organized candidate committees, providing little more than financial assistance, just didn't do the job."

AMPAC's program now is educational, looking both generally and specifically, to the

campaigns in 1964. It aims at making doctors and their wives politically aware. It tries to teach the practice of politics in order to improve the effectiveness of amateur political activity. Over all, AMPAC's program is idealistic and democratic, as well as hard-headedly practical. By encouraging the political activity of otherwise passive citizens, it is helping to keep our democracy vital and healthy. By providing useful basic political education courses, it enables those of us who deplore and look askance to do something in a meaningful way.

It is to be hoped that physicians in every county organize a political wing along the lines suggested by AMPAC. If AFL–CIO's Committee on Political Education (COPE) can prepare now for the 1964 campaigns, so can we who are disturbed by the take-over of our government by special interest groups. But the time to do it is now. If we have been knocked to the floor before, we must get up now and get ready for 1964. If we're serious about our principles, medical political action must be undertaken, and we dare not wait until October 1964 to get started.—D. N. G.

CONFERENCE ON

Health Fads and Fallacies

Sponsored by

THE STATE MEDICAL SOCIETY OF WISCONSIN

THURSDAY, FRIDAY, SATURDAY

APRIL 18–19–20

Presidents' Room, State Medical Society Headquarters, Madison

THURSDAY—PUBLIC EDUCATION FOR PROTECTION AGAINST QUACKERY

FRIDAY— WHAT THE PRACTITIONER SHOULD KNOW ABOUT HEALTH FALLACIES

SATURDAY—RESPONSIBILITY FOR CONTROLLING HEALTH FADS AND FALLACIES

What are the problems in quackery in Wisconsin? Are our present laws adequate to cope with them? What should the practitioner know? The general public? The farmer, lawyer, law enforcement officer? Prominent state and national speakers will provide some of the answers. Numerous exhibits will demonstrate fads and fallacies in specialized fields such as cancer, arthritis and rheumatism.

OPEN TO THE PUBLIC

Encourage people in your community to attend this important conference, and plan to attend yourself!

Honoring the 50th Anniversary of Marquette University School of Medicine, Milwaukee

STATE
MEDICAL
SOCIETY
OF
WISCONSIN

ANNUAL MEETING

MAY 6·7·8·9
1963

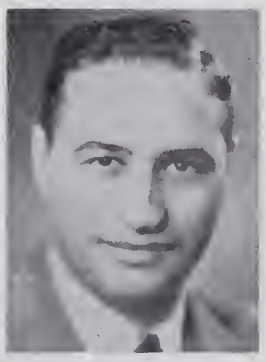
MILWAUKEE AUDITORIUM
HOTEL SCHROEDER

Milwaukee

R. W. FARNSWORTH, M.D.
Chairman, Commission on Scientific Medicine (left)

P. T. BLAND, M.D.
Chairman, Round Table Luncheons (lower left)

A. R. CURRERI, M.D.
Chairman, General Program (lower right)



Each year brings new discoveries and varying modes of therapy of concern to every alert physician. With this in mind, the Commission on Scientific Medicine has arranged a varied and interesting program for the 1963 Annual Meeting. Participation in this meeting by way of attendance is an important part of a physician's progress in medical knowledge.

1963 ANNUAL MEETING
TIMETABLE

MONDAY, MAY 6

6:00 p.m.—Buffet supper for Delegates and Officers, at Hotel Schroeder
6:30 p.m.—Registration of House of Delegates, at Hotel Schroeder
7:00 p.m.—First session, House of Delegates, at Hotel Schroeder

TUESDAY, MAY 7

8:00 a.m.—Registration at Auditorium
Exhibits open at Auditorium
9:00 a.m.—Reference Committees, House of Delegates, at Hotel Schroeder
9:00 a.m.—Medical Care of the Aged conference, at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Marq. U. and U. of W. medical schools' alumni luncheons at Auditorium
2:00 p.m.—Medical Care of the Aged conference continued, at Auditorium
7:30 p.m.—Second session, House of Delegates, at Hotel Schroeder
8:00 p.m.—Fireside Conferences, at Hotel Schroeder

WEDNESDAY, MAY 8

8:00 a.m.—Registration at Auditorium
9:00 a.m.—Exhibits open at Auditorium
9:00 a.m.—Third Session, House of Delegates, at Hotel Schroeder
9:00 a.m.—General Scientific Program, at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Luncheon for officers and trustees of SMS Charitable, Educational and Scientific Foundation, at Hotel Schroeder
12:15 p.m.—Luncheon for Wisconsin Clinic Managers Association, at Milwaukee Athletic Club
2:15 p.m.—Special Interest Programs on obstetrics and gynecology, pathology, psychiatry, and radiology, at Auditorium
6:15 p.m.—President's reception, at Hotel Schoeder
7:15 p.m.—Annual dinner, at Hotel Schroeder

THURSDAY, MAY 9

8:00 a.m.—Registration at Auditorium
9:00 a.m.—Exhibits open at Auditorium
9:00 a.m.—Medical Aspects of Sports conference, at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Past President's luncheon, at Hotel Schroeder
2:00 p.m.—Special Interest Programs on anesthesiology (at Auditorium), ophthalmology and otolaryngology (at Hotel Schroeder), pediatrics (at Auditorium), and surgery (at Auditorium)

ANNUAL MEETING PROGRAM
ARRANGEMENTS UNDER DIRECTION OF

Commission on Scientific Medicine

Richard Farnsworth, M.D._____Janesville
Chairman

Anthony R. Curreri, M.D._____Madison
General Program Chairman

P. T. Bland, M.D._____Westby
Round Table Luncheons

G. E. Collentine, Jr., M.D._____Milwaukee
Scientific Exhibits

John K. Curtis, M.D._____Madison
Special Assignments

John S. Hirschboeck, M.D._____Milwaukee
Dean, Marquette University School of Medicine

V. S. Falk, Jr., M.D._____Edgerton
Medical Editor, *The Wisconsin Medical Journal*

* * *

★ **REGISTRATION:** Pick up your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Fifth and Kilbourn Streets. The time Tuesday, 8:00 a.m.–4:30 p.m.; Wednesday and Thursday, 8:00 a.m.–4:00 p.m. Admittance by badge only.

★ **CERTIFIED GUESTS:** Medical students, medical assistants and hospital personnel will be admitted on Wednesday, May 8, after 12:00 noon, on Thursday, May 9, between 9:00 a.m. and 3:00 p.m. Interns and residents admitted without registration fee, if certified by hospital. Members of the Wisconsin State Dental Society and out-of-state physicians who are members of their county and state medical societies admitted by membership cards.

★ **VA and M.D.'s IN MILITARY SERVICE:** *Members of the Veterans Administration must be members of the State Medical Society to be admitted.* Physicians in the armed services admitted by presenting certification of current military status.

BEFORE LEAVING FOR MEETING
GIVE YOUR SECRETARY THIS INFORMATION

TELEPHONE SERVICE: Registration Desk, Milwaukee Auditorium—BR 1–9609. *For Milwaukee MDs, Direct call through BR 3–7700, Ext. 200, and it will be relayed to a special phone near the main meeting hall at the Auditorium.* For those at Luncheons: 5th Floor Foyer phone at Hotel Schroeder—BR 1–7250. Tell your secretary the room number of the luncheon, so we can locate you!

PRESS and STAFF ROOM
Room 509
HOTEL SCHROEDER

Special Events Honoring
THE FIFTIETH ANNIVERSARY

Marquette University School of Medicine

In 1913, the Milwaukee Medical College and Wisconsin College of Physicians joined with Marquette University to form a new medical school. Since that date the Marquette University School of Medicine has been a major factor in establishing the high level of medical care enjoyed today by Wisconsin residents.

A half-century of service to Wisconsin, education of a generation of physicians, countless contributions to the field of medicine—for these and other accomplishments the State Medical Sociey of Wisconsin, at its 122nd annual meeting, honors the Fiftieth Anniversary of the Marquette University School of Medicine.

A special issue of the *Wisconsin Medical Journal* will be devoted to papers presented at the annual meeting by Marquette alumni.

ANNUAL DINNER

Wed., May 8

MAIN SPEAKER
A Marquette Alumnus

Edward R. Annis, M. D.
President-Elect
American Medical Association

Out-of-State Guest Lecturers Who Are Alumni of Marquette University School of Medicine

ROBERT W. BAILEY, M. D.
(Class of 1946), Department of Orthopedic Surgery, University of Michigan Medical School, Ann Arbor, Mich.

IVAN D. BARONOFSKY, M. D.
(Class of 1943), Clinical Professor of Surgery, University of Southern California School of Medicine, San Diego, Calif.

JOHN J. BONICA, M. D.
(Class of 1942), Professor and Chairman, Department of Anesthesiology, University of Washington School of Medicine, Seattle, Wash.

J. E. GERACI, M. D.
(Class of 1942), Clinical Section, Mayo Clinic, Rochester, Minn.

FRANK J. GLASSY, M. D.
(Class of 1946), Dept. of Pathology, Sutter Community Hospitals, Sacramento, Calif.

JOHN ROMANO, M. D.
(Class of 1934), Professor of Psychiatry and Psychiatrist-In-Chief, Strong Memorial Hospital, University of Rochester School of Medicine, Rochester, N. Y.

Bailey

Baronofsky

Boies

Bonica

Connor

Davis

Geraci

Glassy

OUT-OF-STATE GUEST LECTURERS

ROBERT W. BAILEY, M. D.

Associate Professor of Surgery, University of Michigan Medical School; Administrative Head, Section of Orthopaedic Surgery, Department of Surgery, University of Michigan Medical Center, Ann Arbor, Mich. (Marquette graduate 1946)

IVAN D. BARONOFSKY, M. D.

Clinical Professor of Surgery, University of Southern California School of Medicine (Los Angeles), San Diego, Calif. (Marquette graduate 1943)

LAWRENCE R. BOIES, M. D.

Professor and Chairman, Department of Otolaryngology, University of Minnesota Medical School, Minneapolis, Minn.

JOHN J. BONICA, M. D.

Professor and Chairman, Department of Anesthesiology, University of Washington School of Medicine, Seattle, Wash. (Marquette graduate 1942)

WILLIAM E. CONNOR, M. D.

Department of Internal Medicine, State University of Iowa, Iowa City, Ia.

LAWRENCE A. DAVIS, M. D.

Professor of Radiology, University of Louisville School of Medicine, Louisville, Ky.

R. H. FERGUSON, M. D.

Clinical Section, Mayo Clinic, Rochester, Minn.

J. E. GERACI, M. D.

Clinical Section, Mayo Clinic, Rochester, Minn. (Marquette graduate 1942)

FRANK J. GLASSY, M. D.

Clinical Pathologist, Sacramento Clinical Laboratories and Sutter Community Hospitals, Sacramento, Calif. (Marquette graduate 1946)

EDWARD CUYLER HAMMOND, Sc. D.

Director, Statistical Research Section, Medical Affairs Department, American Cancer Society, New York, N. Y.

GEORGE J. HAMWI, M. D.

Professor of Medicine and Director, Division of Endocrinology and Metabolism, Ohio State University, Columbus, O.

ELIHU S. HOWLAND, M. D.
Chicago, Ill.

ORMAND C. JULIAN, M. D.
Professor of Surgery, University of Illinois College of Medicine, Chicago, Ill.

PETER C. KRONFELD, M. D.
Professor and Chairman, Department of Ophthalmology, Illinois Eye and Ear Infirmary, University of Illinois College of Medicine, Chicago, Ill.

ELLIOT O. LIPCHIK, M.D.
Department of Radiology, Strong Memorial Hospital, Rochester, N. Y.

C. G. MENDELSON, M. D.
Henry Ford Hospital, Department of Dermatology, Detroit, Mich.

CLYDE L. RANDALL, M. D.
Chairman, Department of Obstetrics and Gynecology, State University of New York at Buffalo, Buffalo, N. Y.

JOHN ROMANO, M. D.
Professor of Psychiatry, Psychiatrist-in-Chief, University of Rochester School of Medicine and Dentistry and Strong Memorial Hospital, Rochester, N. Y. (Marquette graduate 1934)

ROBERT M. SMITH, M. D.
Director of Anesthesia, Children's Hospital Medical Center, and Clinical Professor of Anesthesiology, Harvard Medical School, Boston, Mass.

JEREMIAH STAMLER, M. D.
Director, Chronic Disease Control Division, City of Chicago Board of Health, Chicago, Ill.

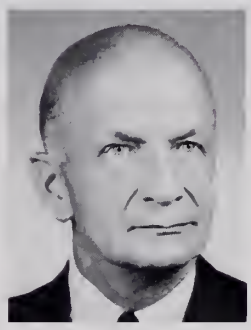
FREDRICK J. STARE, M. D.
Department of Nutrition, Harvard University School of Public Health, Boston, Mass.

HERBERT A. WENNER, M. D.
Associate Professor of Pediatrics and Bacteriology, Department of Pediatrics, Section of Virus Research, University of Kansas Medical Center, Kansas City, Kan.

GRANGER E. WESTBERG, D. D.
Associate Professor of Religion and Health, Medical and Theological Faculties, University of Chicago, Chicago, Ill.

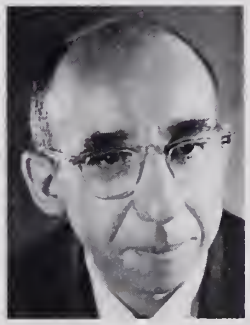
Hammond

Hamwi


Kronfeld

Randall

Romano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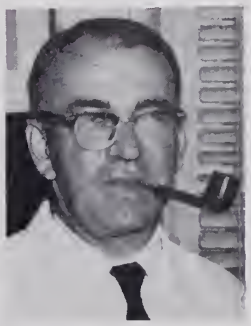
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MILWAUKEE AUDITORIUM

PROGRAM • ANNUAL MEETING

May 6, 7, 8, 9, 1963 • Milwaukee Auditorium • Hotel Schroeder

MONDAY, MAY 6

P.M.

6:00—BUFFET SUPPER for Delegates and Officers
Hotel Schroeder, Pere Marquette Room (fifth floor)

6:30—REGISTRATION OF THE HOUSE OF DELEGATES
Hotel Schroeder (fifth floor foyer)

7:00—FIRST SESSION: HOUSE OF DELEGATES
Hotel Schroeder, Ball Room (fifth floor)

HOUSE OF DELEGATES

Meetings of the House of Delegates are regarded as among the most important functions of the Annual Meeting of the State Medical Society. Reports of the officers and committees, as well as new business, will be presented at the initial session of the House at 7:00 p.m., Monday, May 6.

ALL MEETINGS OF THE HOUSE AND REFERENCE COMMITTEES WILL BE HELD AT HOTEL SCHROEDER

TUESDAY, MAY 7

A.M.

8:00—REGISTRATION AND OPENING OF SCIENTIFIC AND TECHNICAL EXHIBITS
Registration: Kilbourn St. Entrance: Milwaukee Auditorium
Exhibits in Bruce Hall and on Stage: Milwaukee Auditorium

9:00—REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES

COMMITTEE ON NOMINATIONS:
Hotel Schroeder, Pine Room (fifth floor)

COMMITTEE ON RESOLUTIONS:
Hotel Schroeder, Ballroom (fifth floor)

COMMITTEE ON REPORTS OF OFFICERS:
Hotel Schroeder, Room 507 (fifth floor)

COMMITTEE ON REPORTS OF STANDING COMMITTEES:
Hotel Schroeder, Room 508 (fifth floor)

All those concerned with work of these committees, who wish to express their views on reports or resolutions to be acted upon at the second session of the House, on Tuesday evening, are asked to please appear before the appropriate Reference Committee **before noon on Tuesday,** so proper reports can be prepared on Tuesday afternoon.

TUESDAY, MAY 7

PLANKINTON HALL, MILWAUKEE AUDITORIUM

Medical Care of the Aged

A special conference sponsored by the State Medical Society's Division on Aging of the Commission on State Departments, in cooperation with the Wisconsin Society of Internal Medicine and the Wisconsin Academy of General Practice.

* * *

MODERATOR FOR THE CONFERENCE: **Adolph M. Hutter,** M.D., Fond du Lac, Chairman of the Division on Aging

A.M.

9:00—CURRENT CONCEPTS OF ARTERIOSCLEROSIS AND HYPERTENSION

Moderator: **Francis F. Rosenbaum,** M.D., Milwaukee

1. **CURRENT PATHOPHYSIOLOGICAL CONCEPTS OF ARTERIOSCLEROSIS AND HYPERTENSION**
   Paul Kimmelsteil, M.D., Milwaukee
2. **PITFALLS IN DRUG THERAPY**
   Charles W. Crumpton, M.D., Madison
3. **THE PRESENT SURGICAL APPROACH**
   Ormand C. Julian, M.D., Chicago
   (Lecture sponsored by the Wisconsin Heart Association)

9:45—Questions

10:00—Recess

10:30—DIABETES AND SMOKING AS SPECIAL PROBLEMS IN THE AGED

Moderator: **Warren K. Simmons,** M.D., Rhinelander; President, Wisconsin Society of Internal Medicine

1. **MANAGEMENT OF THE ELDERLY DIABETIC**
   George Hamwi, M.D., Columbus, Ohio
2. **SMOKING AS A SPECIAL PROBLEM IN THE AGED**
   a. **Smoking in Relation to Mortality and Changes in Bronchial Epithelium**
      Edward Cuyler Hammond, Sc.D., New York City
      (Lecture sponsored by the American Cancer Society, and its Wisconsin and Milwaukee Divisions)
   b. **Smoking in Pulmonary Disease, Fibrosis and Emphysema**
      Ross C. Kory, M.D., Milwaukee
   c. **Smoking and Asthma**
      John R. Talbot, M.D., Madison

P.M.

12:15—LUNCHEONS

MILWAUKEE AUDITORIUM

1. **UNIVERSITY OF WISCONSIN MEDICAL SCHOOL ALUMNI ASSOCIATION**
   Juneau Hall
   Speaker: Major new administrative appointee
   Cost of luncheon: $4.00, including cocktails and service. Make reservations direct to Mr. Ralph Hawley, 418 N. Randall Avenue, Madison 5, Wisconsin. Make your check payable to U. of W. Medical Alumni Association.
2. **MARQUETTE UNIVERSITY SCHOOL OF MEDICINE ALUMNI ASSOCIATION**
   Market Hall
   Cost of luncheon: $2.50, including service. Make reservations direct to Mr. Ray Pfau, 620 N. 14th Street, Milwaukee 3, Wisconsin.

HOTEL SCHROEDER

(See page 182 for reservation form)

1. **THE ROLE OF THE KIDNEY IN GOUT**
   Richard H. Ferguson, M.D., Rochester, Minnesota
   Chairman: Milton Borman, M.D., Milwaukee
2. **DETECTION OF UTERINE CANCER**
   E. Cuyler Hammond, Sc.D., New York City
   Chairman: R. F. Mattingly, M.D., Milwaukee
3. **RECENT ADVANCES IN THYROID DISEASE**
   George J. Hamwi, M.D., Columbus, Ohio
   Chairman: Edward K. Ryder, Jr., M.D., Madison
4. **SURGERY IN CHRONIC OCCLUSION OF THE FEMORAL ARTERY**
   Ormand C. Julian, M.D., Chicago
   Chairman: James E. Conley, M.D., Milwaukee
5. **DAIRY PRODUCTS IN A DAIRY STATE—OR "TAKING THE BULL BY THE HORNS!"**
   Fredrick J. Stare, M.D., Boston
   Chairman: Warren K. Simmons, M.D., Rhinelander
   (This is the "official" luncheon of the Wisconsin Society of Internal Medicine, but it is "open" to all members of the State Medical Society, so long as seating is available)

A SPECIAL ANNUAL MEETING FEATURE

MEDICAL ART SALON

Milwaukee Auditorium, May 7–8–9

Sponsored by the Woman's Auxiliary of the State Medical Society of Wisconsin

(See the January and February issues of WMJ for details)

TUESDAY, MAY 7 *continued*

PLANKINTON HALL, MILWAUKEE AUDITORIUM

2:00—NUTRITIONAL PROBLEMS OF THE AGED

Moderator: **Joseph S. Devitt,** M.D., Milwaukee; President, Wisconsin Academy of General Practice

1. **GENERAL PRINCIPLES, THE HAZARDS OF FADDISM AND QUACKERY, AND PRACTICAL POINTS**
   Fredrick J. Stare, M.D., Boston
   (The Conrad Elvehjem Memorial Lecture sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin)
2. **DIET AND CARDIOVASCULAR DISEASE**
   J. Stamler, M.D., Chicago
3. **DIET AND SERUM CHOLESTEROL IN THE AGED**
   William E. Connor, M.D., Iowa City

3:00—Recess

Moderator: **Adolph M. Hutter,** M.D., Fond du Lac

3:30—CURRENT CONCEPTS OF OSTEOARTHRITIS AND OSTEOPOROSIS

Richard H. Ferguson, M.D., Rochester, Minnesota

(Lecture sponsored by Wisconsin Chapter of the Arthritis and Rheumatism Foundation)

4:00—PSYCHIATRIC ASPECTS OF AGING

1. **PSYCHIATRIC ASPECTS OF PREPARATION FOR DEATH**
   Elihu S. Howland, M.D., Chicago
2. **THE MINISTER AND THE DOCTOR MEET**
   Granger E. Westberg, D.D., Chicago

5:00—Adjournment of the Conference

GRANGER E. WESTBERG, D.D.

Associate Professor of Religion and Health, Medical and Theological Faculties, University of Chicago, Chicago, Ill.

NONSCIENTIFIC EVENT

Second Session of the House of Delegates

Hotel Schroeder, Ballroom (fifth floor)

Tuesday, May 7, 7.30 p.m.

8:00—FIRESIDE CONFERENCES

EAST ROOM, HOTEL SCHROEDER
fifth floor
(See details in accompanying box)

FIRESIDE CONFERENCES

Tuesday, May 7—Hotel Schroeder

Dinner—6:30 p.m. Conference—8 p.m.

Sponsored by the Wisconsin Chapter of the American College of Chest Physicians

Eleven subjects to be discussed simultaneously at eleven tables. Physicians are welcome to table hop, listen or participate in the informal discussions. Refreshments will be served. Subjects to be covered and the leaders of the discussions are as follows:

1. CORONARY DISEASE—discussion of problems in diagnosis, management, and complications thereof.
   Howard Correll, M.D., Milwaukee; *Julius Meyer,* M.D., Milwaukee; *Herman Shapiro,* M.D., Madison.
2. CARDIAC SURGERY—with emphasis on selection of cases.
   Vincent Gott, M.D., Madison; *Derward Lepley,* Jr., M.D., Milwaukee; *William Young,* M.D., Madison; *Armin Baier,* M.D., Milwaukee.
3. ELECTROCARDIOGRAMS—what they tell us; what they do not.
   D. J. Nuyda, M.D., Milwaukee; *Francis Rosenbaum,* M.D., Milwaukee; *Richard Wasserburger,* M.D., Madison.
4. ACUTE RHEUMATIC FEVER—a discussion of diagnosis and management.
   William J. Gallen, M.D., Milwaukee; *Gerson Bernhardt,* M.D., Milwaukee.
5. CLINICAL CARDIOLOGY—with special attention to problems in:
   Stethoscopic and physical examination of the heart
   John Huston, M.D., Milwaukee.
   Differential diagnosis of chest pain—cardiac or non-cardiac
   George Hellmuth, M.D., Milwaukee.
   Treatment of Cardiac failure
   Mischa Lustok, M.D., Milwaukee.

(Continued on page 171)

FIRESIDE CONFERENCES *continued*

6. CHRONIC LUNG DISEASE—diagnosis and problems in management with attention primarily on 'chronic bronchitis', bronchiectasis, pneumoconioses, and chronic pulmonary emphysema.
   Leon Hirsh, M.D., Milwaukee; *Ross Kory*, M.D., Milwaukee; *Avrum Organick*, M.D., Milwaukee; *John Rankin*, M.D., Madison.

7. BRONCHIAL ASTHMA—a discussion of problems in management.
   John Arkins, M.D., Milwaukee; *Abe Sosman*, M.D., Milwaukee; *John Talbot*, M.D., Madison.

8. CHEST X-RAYS—problems in interpretation and pitfalls in reading.
   John Amberg, M.D., Milwaukee; *Donald Babbitt*, M.D., Milwaukee; *Jerome Marks*, M.D., Milwaukee.

9. PULMONARY FUNCTION STUDIES—their value, problems in interpretation, and techniques.
   J. Bernard Gee, M.D., Madison; *David Rosenzweig*, M.D., Milwaukee; *Walter Thiede*, M.D., Milwaukee.

10. PULMONARY TUBERCULOSIS AND FUNGUS DISEASES—a discussion of the recent advances in diagnosis and treatment thereof.
    Helen Dickie, M.D., Madison; *William Stead*, M.D., Milwaukee.

11. LUNG CANCER—the problem discussed from the standpoint of diagnosis, prevention, and treatment.
    Fred J. Ansfield, M.D., Madison; *Anthony Curreri*, M.D., Madison; *John R. Pellett*, M.D., Madison; *Albert Pemberton*, M.D., Milwaukee.

WEDNESDAY, MAY 8

A.M.

8:00—REGISTRATION: Kilbourn Street Entrance, Milwaukee Auditorium

8:00—EXHIBIT REVIEW: Scientific and Tehnical, Bruce Hall, Milwaukee Auditorium

NONSCIENTIFIC EVENT

Third Session of the House of Delegates

Hotel Schroeder, Ballroom (fifth floor)

Wednesday, May 8, 9:00 a.m.

General Scientific Program

PLANKINTON HALL, MILWAUKEE AUDITORIUM

Moderator: **A. R. Curreri,** M.D., Madison

A.M.

9:00—MOST RECENT DEVELOPMENTS IN CHEMOTHERAPY IN THE TREATMENT OF CARCINOMA (Panel)
REGIONAL CHEMOTHERAPY FOR CANCER
(Guest speaker pending)
Discussants: **A. R. Curreri,** M.D., Madison and **John Hurley,** M.D., Milwaukee

10:00—Recess to view exhibits

10:45—Continuation of General Scientific Program
Moderator: **John S. Hirschboeck,** M.D., Milwaukee

10:45—FREQUENT EMOTIONAL CRISES OF PATIENTS AND THEIR FAMILIES (Suggestions for their Understanding and Management)
John Romano, M.D., Rochester, New York
(Rogers Memorial Lecture, sponsored by Rogers Memorial Hospital, Oconomowoc)

11:15—THE ANTIBIOTIC THERAPY OF BACTERIAL ENDOCARDITIS
J. E. Geraci, M.D., Clinical Section, Mayo Clinic, Rochester, Minnesota

11:45—Questions

P.M.

12:15—LUNCHEONS
(See page 182 for reservation form)

HOTEL SCHROEDER

1. **OBSTRUCTING LESIONS OF THE LOWER URINARY TRACT**
   Elliot O. Lipchik, M.D., Rochester, N. Y.
   Chairman: John Amberg, M.D., Milwaukee
   (Luncheon of Wisconsin Radiological Society, but "open" so long as seating available)
2. **FEVER OF OBSCURE ORIGIN**
   J. E. Geraci, M.D., Rochester, Minnesota
   Chairman: William W. Stead, M.D., Milwaukee
3. **LABORATORY DIAGNOSIS OF COLLAGEN DISEASE**
   Frank J. Glassy, M.D., Sacramento, California
   Chairman: David J. Carlson, M.D., Milwaukee
   (Luncheon of Wisconsin Society of Pathology, but "open" so long as seating available)
4. **THE ELECTIVE INDUCTION OF LABOR**
   Clyde L. Randall, M.D., Buffalo, New York
   Chairman: Ben M. Peckham, M.D., Madison
   (Luncheon of Wisconsin Society of Obstetrics and Gynecology, but "open" to all, so long as seating available)

(Luncheons continued)

WEDNESDAY, MAY 8 *continued*

Luncheons *continued*

5. **UNANSWERED QUESTIONS ON "EMOTIONAL CRISES OF PATIENTS AND THEIR FAMILIES"**
   (Based on Morning Lecture)
   John Romano, M.D., Rochester, New York
   Chairman: Charles Landis, M.D., Milwaukee
   (Luncheon of Wisconsin Psychiatric Association, but "open" to all, so long as seating available)

6. **ELECTROCARDIOGRAPHIC PATTERNS IN CHILDREN**
   Richard H. Wasserburger, M.D., Madison

NONSCIENTIFIC LUNCHEON

Charitable, Educational and Scientific Foundation

ANNUAL MEETING

Hotel Schroeder, Pere Marquette Room
Fifth Floor

Wednesday, May 8, 12:15 p.m.

All officers and county medical society representatives requested to attend. NO CHARGE FOR THIS LUNCHEON. Following luncheon there will be a report of Foundation activities and plans for the ensuing year.

Special Interest Programs

MILWAUKEE AUDITORIUM

While these programs have been prepared in cooperation with the designated specialty society, all are "open" meetings, and members of the State Medical Society are urged to attend the lectures of greatest interest to them. Each specialty session will start at 2:15 p.m.

OBSTETRICS AND GYNECOLOGY

PLANKINTON HALL (SECOND FLOOR)

Program planned cooperatively with Wisconsin Society of Obstetrics and Gynecology

Moderator: **Ben M. Peckham,** M.D., Madison; President, Wisconsin Society of Obstetrics and Gynecology

2:15—SELECTION OF TREATMENT OF GYNECOLOGIC MALIGNANCIES
Clyde L. Randall, M.D., Buffalo, New York

2:45—Discussion

3:00—Recess to view exhibits

3:30—THE INFLUENCE OF AGE AND PARITY ON PREGNANCY
George S. Kilkenny, M.D., Milwaukee

4:00—MALIGNANT METASTASES TO THE ENDOMETRIUM
Alex Krembs, M.D. and **Rita Marino,** M.D., Milwaukee

4:15—Discussion

4:30—Business meeting

PATHOLOGY

JUNEAU HALL (FIRST FLOOR)

Program planned cooperatively with Wisconsin Society of Pathologists

Moderator: **David J. Carlson,** M.D., Milwaukee; President, Wisconsin Society of Pathologists

2:15—COLLAGEN DISEASE AND IMMUNITY
Frank J. Glassy, M.D., Sacramento, California

2:45—Questions and Discussion

3:00—Recess to view exhibits

3:45—PANEL ON "COLLAGEN DISEASES"
Moderator: D. B. Claudon, M.D., Milwaukee

a. **The Chemistry of Fibrinoid**
   Charles Altshuler, M.D., Milwaukee
b. **Morphologic Aspects of Collagen Disease**
   Paul Kimmelstiel, M.D., Milwaukee
c. **Clinical Aspects of Collagen Diseases**
   John Smith, M.D., Milwaukee

PSYCHIATRY

NORTH KILBOURN HALL (FIRST FLOOR)

Program planned cooperatively with Wisconsin Psychiatric Association

Moderator: **Charles W. Landis,** M.D., Milwaukee; President, Wisconsin Psychiatric Association

2:15—THE PSYCHIATRIC REFERRAL AND OTHER ASPECTS OF RELATIONSHIPS BETWEEN THE PSYCHIATRIST AND THE REFERRING PHYSICIAN
John Romano, M.D., Rochester, New York

2:45— Discussant: **Samuel S. Sorkin,** M.D., Evansville

2:55—Questions and Discussion

3:10—Recess to view exhibits

3:45—SPECIFICITY IN PSYCHOSOMATIC DISEASE
David T. Graham, M.D., Madison

4:15—Discussant: **John Romano,** M.D., Rochester, N.Y.

4:25—General Discussion and Questions

RADIOLOGY

WALKER HALL (FIRST FLOOR)

Program planned cooperatively with Wisconsin Radiological Society

Moderator. **H. H. Wright,** M.D., Milwaukee; President, Wisconsin Radiological Society

2:00—Topic pending
Speaker pending

2:15—ROENTGENOLOGICAL DIAGNOSIS OF INTRATHORACIC DISEASE IN THE NEWBORN
Lawrence A. Davis, M.D., Louisville, Kentucky

2:45—Questions and Discussion

3:00—Recess to view exhibits

3:30—Topic pending
Speaker pending

3:45—THE SMALL ESOPHAGEAL HIATUS HERNIA
Elliot O. Lipchik, M.D., Rochester, N. Y.

4:15—Topic pending

4:30—Business meeting

NONSCIENTIFIC EVENT

President's Reception
(for those attending annual dinner)

Hotel Schroeder, East Room, (fifth floor)

Wednesday, May 8, 6:30 p.m.

* * *

Annual Dinner

Hotel Schroeder, Ballroom (fifth floor)

Wednesday, May 8, 7:15 p.m.

See details elsewhere in this program

THURSDAY, MAY 9

A.M.
8:30—REGISTRATION
Kilbourn Street Entrance, Milwaukee Auditorium

8:30—SCIENTIFIC AND TECHNICAL EXHIBITS
Bruce Hall, Milwaukee Auditorium

Medical Aspects of Sports

PLANKINTON HALL, MILWAUKEE AUDITORIUM

All physicians in any way associated with high school or college sports are urged to attend this meeting and to participate in the discussion. Program planned cooperatively with Wisconsin Interscholastic Athletic Association and the State Medical Society's Division on School Health of the Commission on State Departments.

Moderator: **James C. H. Russell,** M.D., Fort Atkinson; Member, Division on School Health

A.M.
9:00—KNEE INJURIES
Robert W. Bailey, M.D., Ann Arbor, Michigan
Discussants: **James W. Nellen,** M.D., Green Bay; and **Frederic W. Reichardt,** M.D., Stevens Point

10:00—Recess to view exhibits

11:00—COMMON DERMATOLOGIC PROBLEMS ASSOCIATED WITH SPORTS AND HOW BEST TO MEET THEM
C. G. Mendelson, M.D., Detroit, Mich.
Discussants: **Sture A. M. Johnson,** M.D., Madison; and **Donald M. Ruch,** M.D., Milwaukee

P.M.
12:15—LUNCHEONS
(See page 182 for reservation form.)
HOTEL SCHROEDER

1. THE ORTHOPEDIC AND NEUROLOGICAL ASPECTS OF CERVICAL SPINE INJURY
Robert W. Bailey, M.D., Ann Arbor, Michigan
Chairman: Richard C. Wixson, M.D., Madison
(Luncheon of Wisconsin Orthopedic Society, but "open" to all so long as seating available)

2. DIAPHRAGMATIC HERNIA
Ivan D. Baronofsky, M.D., San Diego, California
Chairman: J. W. Gale, M.D., Madison

3. RECENT ADVANCES IN OBSTETRIC ANESTHESIA
John J. Bonica, M.D., Seattle, Washington
Chairman: Harry E. Thimke, M.D., Eau Claire
(Luncheon of Wisconsin Society of Anesthesiologists, but "open" to all so long as seating available)

(Luncheons continued)

Luncheons *continued*

4. **E.E.N.T. LUNCHEON**

Business meeting at 1:00 p.m. with scientific meeting at 2:00 p.m.

(See program on page 175)

All E.E.N.T. members are urged to make reservations for this luncheon, to participate in the important business session of the Section, and be prepared to participate in the scientific program which will immediately follow the business session.

5. **THE DIAGNOSIS AND TREATMENT OF GLAUCOMA BY PHYSICIANS IN GENERAL PRACTICE**

Peter C. Kronfeld, M.D., Chicago

Chairman: Carl N. Neupert, M.D., Madison
(Luncheon of Wisconsin Society of Public Health Physicians, but "open" to all so long as seating available)

6. **WARTS: PAST, PRESENT AND FUTURE**

C. G. Mendelson, M.D., Detroit, Michigan
Chairman: Sture A. M. Johnson, M.,D., Madison
(Luncheon of Wisconsin Society of Dermatology, but "open" to all so long as seating available)

7. **PROPER ROLE OF THE PRACTICING PHYSICIAN IN THE USE OF NEW DRUGS**

Ovid O. Meyer, M.D., Madison

8. **MEDICAL TREATMENT OF PEPTIC ULCER**

John F. Morrissey, M.D., Madison

9. **CLINICAL USE OF THE MICROBIOLOGY LABORATORY**

Herbert A. Wenner, M.D., Kansas City, Kansas

Chairman: Thomas V. Geppert, M.D., Madison
(Luncheon of Wisconsin Academy of Pediatrics, but "open" to all so long as seating available)

NONSCIENTIFIC LUNCHEON

Past President's Luncheon

HOTEL SCHROEDER

Parlor G (fourth floor)

Thursday, May 9, 12.15 p.m.

All Past Presidents to attend this luncheon. Dr. N. A. Hill, Madison, as immediate past president, will be the host; and Dr. W. J. Egan, Milwaukee, incoming president, will be special guest.

Special Interest Programs

MILWAUKEE AUDITORIUM

While these programs have been prepared in cooperation with the designated specialty society, all are "open" meetings; and members of the State Medical Society are urged to attend the lectures of greatest interest to them.

ANESTHESIOLOGY

JUNEAU HALL (FIRST FLOOR)

Moderator: **Harry E. Thimke,** M.D., Eau Claire; President, Wisconsin Society of Anesthesiologists

2:15—ANESTHESIA FOR INFANTS

Robert M. Smith, M.D., Director of Anesthesia, Children's Hospital Medical Center, Boston, Massachusetts; and Clinical Professor of Anesthesiology, Harvard Medical School.

2:30—REGIONAL ANESTHESIA IN CHILDREN

John J. Bonica, M.D., Professor and Chairman of the Department of Anesthesiology, University of Washington School of Medicine, Seattle, Washington

3:00—Recess to view exhibits

3:45—JOINT MEETING OF ANESTHESIOLOGISTS AND PEDIATRICIANS

Juneau Hall (first floor)

Moderator: **Harry E. Thimke,** M.D., Eau Claire; President, Wisconsin Society of Anesthesiologists

3:45—ANESTHESIA FOR POOR RISK PEDIATRIC PATIENTS
Robert M. Smith, M.D., Boston

4:15—Discussion and Questions

OPHTHALMOLOGY AND OTOLARYNGOLOGY

HOTEL SCHROEDER, EAST ROOM (FIFTH FLOOR)

Program planned cooperatively with Section on Ophthalmology and Otolaryngology.

Moderator: **William C. Randolph,** M.D., Manitowoc; Chairman, Section on Ophthalmology and Otolaryngology

12:15—LUNCHEON

All those who will attend the meeting are asked to please make reservations for lunch,

so that the business session and scientific program can be carried out with all interested members present.

1:00—BUSINESS MEETING

2:00—CURRENT TRENDS IN OTOLARYNGOLOGY

Lawrence R. Boies, M.D., Professor and Head of the Department of Otolaryngology, University of Minnesota Medical School, Minneapolis, Minnesota

2:30—Discussion and Questions

2:45—RECENT DEVELOPMENTS IN GLAUCOMA SURGERY

Peter C. Kronfeld, M.D., Chicago

(Speaker provided by Wisconsin State Board of Health)

3:15—Discussion and Questions

PEDIATRICS

WALKER HALL (FIRST FLOOR)

(After 3:45 p.m. in Juneau Hall, with Anesthesiologists)

Program planned cooperatively with Wisconsin Academy of Pediatrics

Moderator: **Thomas V. Geppert,** M.D., Madison; President, Wisconsin Chapter, American Academy of Pediatrics

2:00—NEW VIRUS DISEASES IN PEDIATRICS

Herbert A. Wenner, M.D., Kansas City, Kansas

2:30—Questions

2:40—METABOLIC DISORDERS IN CHILDREN

Harry A. Waisman, M.D., Madison

(Special guest lecture of nonmember, approved by Commission on Scientific Medicine)

3:10—Recess to view exhibits

3:45—JOINT MEETING WITH ANESTHESIOLOGISTS

Juneau Hall (first floor)

ANESTHESIA FOR POOR RISK PEDIATRIC PATIENTS

Robert M. Smith, M.D., Boston, Mass.

4:15—Questions and Discussion

SURGERY

PLANKINTON HALL (SECOND FLOOR)

Program arranged cooperatively with Wisconsin Surgical Society and Wisconsin Society of Orthopedic Surgery.

Moderator. **A. R. Curreri,** M.D., Madison; President, Wisconsin Surgical Society

2:00—AN ANALYSIS OF FRACTURES AND DISLOCATIONS OF THE SPINE

Robert W. Bailey, M.D., Ann Arbor, Michigan

Discussant: **Herman W. Wirka,** M.D., Madison

2:30—SOME CONTROVERSIAL ASPECTS OF BURNS

George E. Collentine, Jr., M.D., Milwaukee

Discussant: **Pending**

2:45—Recess to view exhibits

3:15—PRESIDENTIAL ADDRESS

C. Morrison Schroeder, M.D., Milwaukee

3:30—SURGICAL TREATMENT OF PORTAL HYPERTENSION

Ivan D. Baronofsky, M.D., San Diego, California

(William Beaumont Memorial Lecture)

Discussant: **Pending**

4:00—PROBLEMS IN EXTRACRANIAL CEREBROVASCULAR SURGERY

Leonard W. Worman, M.D., Milwaukee

Discussant: **Pending**

4:15—BUSINESS MEETING

FIFTY YEAR CLUB

Members to Be Honored

KARL K. AMUNDSON, M. D.	CAMBRIDGE
EDWARD F. BARTA, M. D.	MILWAUKEE
HAMILTON A. BOLSTAD, M. D.	DE SOTO
JEFFREY J. BROOK, M. D.	MILWAUKEE
CORNELIUS J. CORCORAN, M. D.	MILWAUKEE
PAUL J. DAILEY, M. D.	ELCHO
JAMES P. DEAN, M. D.	MADISON
GEORGE P. DEMPSEY, M. D.	SOUTH MILWAUKEE
ALBA C. EDWARDS, M. D.	BARABOO
JOHN E. HANKO, M. D.	REEDSBURG
JOHN G. HIRSCHBOECK, M. D.	FORESTVILLE
HENRY F. HOESLEY, M. D.	SHULLSBURG
JOHN T. KLEIN, M. D.	MILWAUKEE
CHARLES F. McCUSKER, M. D.	GLENWOOD CITY
FRANCIS B. MC MAHON, M. D.	MILWAUKEE
ARTHUR A. PLEYTE, M. D.	MILWAUKEE
HERMANN K. ROSMANN, M. D.	CUBA CITY
LEWIS A. SEYMOUR, M. D.	MILWAUKEE

ANNUAL DINNER

Wednesday Evening
May 8

GUEST SPEAKER

Edward R. Annis
M. D.

President-Elect
American Medical
Association

- President's Reception
- Annual Dinner
- Presentation of Fifty-Year Club Awards
- Selections by the Marquette University School of Medicine Glee Club
- Dancing to the music of The Executives

MAIL YOUR ADVANCE REGISTRATION TODAY

See Page 182

Special Dinners or Social Functions

(For members of specialty groups only)

WEDNESDAY, MAY 8

6:00 p.m.—**WISCONSIN SOCIETY OF PATHOLOGISTS** dinner at Mamie's Grotto, 624 East Detroit St. Reservations: Edwin L. Bemis, M.D., Wisconsin Society of Pathologists, 561 N. 15th St., Milwaukee. **No money with reservation,** but please contact Doctor Bemis if you plan to attend, so proper arrangements can be made. **Wives are not to be included.**

7:00 p.m.—**WISCONSIN RADIOLOGICAL SOCIETY** dinner meeting, University Club. Social hour starts at 6:15 p.m. Chairman: Eugene Sengpiel, M.D., Milwaukee. Speaker: L. A. Davis, M.D., Louisville, Ky.—"Surgical Emergencies of the Newborn." Dinner limited to members, physician guests, and radiology residents. Reservations to Robert Byrne, M.D., Columbia Hospital, Milwaukee.

THURSDAY, MAY 9

5:30 p.m.—**WISCONSIN SECTION OF THE AMERICAN ACADEMY OF PEDIATRICS** dinner at the Coach House Motor Inn, 19th and W. West Avenue. Wives welcome. Speaker: Herbert A. Wenner, M.D., Kansas City, Kansas. $5.50 per person. Reservations: Harry Waisman, M.D., 1300 University Ave., Madison 6.

6:00 p.m.—**WISCONSIN SOCIETY OF ANESTHESIOLOGISTS** dinner at the Wisconsin Club. Reservations: Sheldon Burchman, M.D., 250 W. Bergen Court, Milwaukee 17. $7.00 per person, **wives invited.**

7:00 p.m.—**WISCONSIN SURGICAL SOCIETY** dinner meeting at Milwaukee Athletic Club. Meeting open to all members of the WSS, their guests, and their wives. Reservations: Norman O. Becker, M.D., Secretary-treasurer, 104 South Main St., Fond du Lac

7:00 p.m.—**WISCONSIN ORTHOPEDIC SOCIETY** dinner at Athletic Club. Speaker: Robert W. Bailey, M.D., Ann Arbor, Mich.

Scientific Exhibits

MILWAUKEE AUDITORIUM

EXHIBIT HOURS

Tues., May 7 ..... 8:00 a.m.–5:00 p.m.
Wed., May 8 ..... 9:00 a.m.–5:00 p.m.
Thurs., May 9 ..... 9:00 a.m.–3:30 p.m.
(Exhibits "break up" at 3:45 p.m. on Thurs., May 9)

GEORGE E. COLLENTINE, JR., M.D.

Chairman
Scientific
Exhibits

IN MAIN EXHIBIT HALL

18–19—PEDIATRIC THORACIC SURGERY PROBLEMS

Drs. J. W. Gale, A. R. Curreri, J. R. Pellett, and G. M Kroncke, Madison

Includes five view boxes which are self-illuminated and cover separate categories: empyema, tracheo-esophageal fistula, mediastinal tumors, cystic fibrosis, and parenchymal tumors (primary and metastatic). Cut-outs in the boxes show x-rays and case summaries. An outline of the usual management for each of the five major categories accompanies the boxes.

47–48—RENAL-RETINAL PATHOLOGY

Drs. D. A. Roth and B. J. Peters, Wood VA Center, Wood

A teaching exhibit, this presents Kodachrome enlargements of various renal tissues obtained by renal biopsy. Funduscopic photographs of co-existing retinal pathology are displayed in paired panels. In addition, a projector and screen are utilized to demonstrate correlation of retinal and renal abnormalities in various disease states. Normal and abnormal findings are shown.

50—USES AND ADVANTAGES OF BRACHIAL ANGIOGRAPHY

Drs. Marvin Wagner, J. A. Mufson, and A. E. Kagen, Mt. Sinai Hospital, Milwaukee

Consists of x-ray films and descriptive lettering with division of the exhibit into indications, technique, and complications of brachial angiography, and normal and abnormal illustrations.

49—ORTHOPAEDIC SURGERY HARDWARE

Drs. J. R. Stone, Louis Kagen, and P. A. Jacobs, Mt. Sinai Hospital, Milwaukee

Primarily pictorial, the exhibit shows the various types of metal implants available in the orthopaedic surgeons armamentarium. These include hip prostheses, spine jacks, intramedullary rods, etc.

49A—TREATMENT OF LYMPHEDEMA OF THE EXTREMITIES

Drs. M. E. Sattler and R. W. Mann, Surgical and Physical Medicine Departments, Mt. Sinai Hospital, Milwaukee

This is a clinical study of patients with lymphedema of the extremities due to various causes; such as, postmastectomy edema, post-thrombophlebitic edema, and edema due to other venous and lymphatic obstructions. These patients have been treated with intermittent compression in an attempt to improve lymphatic and venous drainage of the extremities. The exhibit includes pictures and measurements of the patients before and after treatment. This method of therapy is an effective means of aiding patients with this disability.

75—PRIMARY MEGALOURETER

Drs. Morris Moel and L. K. Mark, Department of Radiology, Mt. Sinai Hospital, Milwaukee

76—TREATMENT OF DIABETES MELLITUS WITH ACETOHEXAMIDE: A CLINICAL STUDY

Dr. E. H. Tashkin, Mt. Sinai Hospital, Milwaukee

The hypoglycemic activity of the sulfonylureas depends upon the adherence to a basic molecular configuration which when altered results in a loss of its blood-glucose lowering effect. However, this permits the synthesis of many cogeneric substances which retain their hypoglycemic effect. Their degree of activity, duration of action, toxicity, side effects, metabolic pathway as well as their clinical usefulness varies with the changes in molecular structure. This exhibit represents a clinical experience with acetohexamide (N-[4-acetylbenzenesulfonyl]-N' cyclohexylurea) in the treatment of the maturity-onset type of diabetes. It emphasizes the relation of molecular structure to function of the sulfonylureas, its historical development and experiences with one of the more recently synthesized compounds.

76A—DETECTION OF THE METABOLIC PATTERN OF DIABETES MELLITUS IN PREGNANCY: CLINICAL IMPORTANCE

Dr. A. M. Kurzon, Milwaukee

Pregnancy is a dynamic period of stress during which abnormal carbohydrate metabolism may be de-

tected by specific laboratory examinations. The complications of pregnancy in these women predestined for clinical diabetes at a later date are identical to the overt diabetic. Early diagnosis and treatment are necessary to minimize these complications. The most favorable method of detection of the prediabetic is demonstrated and the proper standards listed. Pertinent statistics are demonstrated resulting from a study of more than 7300 patients delivered at Mt. Sinai Hospital.

76B—RECONTRUCTION (BONE) IN ARTHRITIC DISEASES

Wisconsin Chapter, The Arthritis and Rheumatism Foundation, Milwaukee

(Copy Pending)

101—LYMPHOID CELL VARIATIONS IN THE PERIPHERAL BLOOD

Drs. E. L. Bemis, R. S. Haukohl, and Yoshiro Taira, Department of Pathology and Laboratory Medicine, Evangelical Deaconess Hospital, Milwaukee

Exhibit contains illustrations and enlarged photomicrographic transparencies, showing morphologic variations of lymphocytes found in the peripheral blood in health and in disease; i.e., viral diseases, leukemia and lymphosarcoma.

102—AORTOGRAPHY: METHODS AND VALUE

Drs. R. E. Zellmer and W. E. Deschler, Department of Radiology, Evangelical Deaconess Hospital, Milwaukee

Aortography is a practical procedure enabling the clinician to resolve numerous diagnostic problems. The selection of the type of aortogram (retrograde, direct, venous) will depend upon the problem. In general, venous aortography (including nephrotomography) yields gross anatomical details. Direct lumbar aortography is useful in aortic occlusive vascular disease. Retrograde aortography is the method of choice for detailed anatomic evaluation of the aorta, its visceral branches, and femoral arteries. Examples of the various methods of aortography are shown. Several cases demonstrating the usefulness of aortography in the everyday problems of medicine are presented.

103-104—TREATMENT OF THE HANDICAPPED CHILD: THE MULTIDISCIPLINARY APPROACH

Dr. Lucille B. Glicklich, Medical Coordinator of the Kiwanis Children's Center of the Curative Workshop of Milwaukee

An outpatient treatment center for handicapped children is demonstrated. Since the handicapped child is one who by virtue of his disabilities is unable to perform as his normal peers, he presents problems to his parents, his school, his society, and to himself. The team approach to the management of this patient and his family is demonstrated in the cases of the (1) cerebral palsied child, (2) mentally retarded child, (3) child without language, and (4) child with anomalies of his extremities.

105—UNCOMMON TYPES OF CARDIOMEGALY IN INFANCY

Drs. W. J. Gallen and S. R. McCreadie, Milwaukee Children's Hospital, Milwaukee

The exhibit, detailing a small series of unusual and diverse causes of cardiomegaly in the first year of life, consists of case histories, featuring diagnostic procedures, and clinical, radiological, and pathological findings.

106—MODERN TREATMENT OF DUPUYTREN'S DISEASE (PALMAR FIBROMATOSIS)

Drs. W. H. Frackelton and J. L. Teasley, Columbia Hospital, Milwaukee

Dupuytren's disease (palmar fibromatosis) is a common disease, occurring in 1% to 1.5% of general population with a significantly higher incidence in men in the fourth, fifth, and sixth decades of life. The clinical phases of progressive involvement and disability of the hand from this condition is demonstrated by the exhibitors. Treatment is surgical. Surgical procedures appropriate to the different stages of involvement are demonstrated.

107—ATHLETIC DERMATITIS

Dr. D. M. Ruch, Columbia Hospital, Milwaukee

The purpose of this exhibit is to point out through the use of Kodachromes the importance and various types of athletic dermatitis that occur in athletes playing football, basketball, baseball, and those taking part in swimming and track. Prevention is illustrated and emphasis is placed on proper diagnosis of these conditions so that proper treatment can be instituted early in the eruption. Several examples of stress and strain dermatitis prior to the athletic contest is illustrated.

108-109—(1) GROSS TISSUE PATHOLOGY DEMONSTRATION

(2) QUALITY CONTROL IN CLINICAL LABORATORY

Wisconsin Society of Pathologists

The exhibit is in two parts. One part is devoted to presentation and demonstration of gross tissue pathology. The other part concerns "quality control" in the clinical laboratory.

110-111—NEWBORN SURGICAL EMERGENCIES

Dr. Marvin Glicklich, Department of Surgery, St. Luke's Hospital, Milwaukee

The urgency of early diagnosis and treatment of surgical emergencies of the newborn is stressed. Tension pneumothorax, diaphragmatic hernia, esophageal atresia and tracheo-esophageal fistula, intestinal obstructions, and omphaloceles are depicted and discussed with x-ray films, transparencies, drawings, and diagrams.

112—LYMPHANGIOGRAPHY: A NEW DIAGNOSTIC AND THERAPEUTIC TOOL

Drs. J. E. Habbe, H. H. Wright, C. E. Schmidt, A. B. Fidler, T. Simonsen, R. G. Evenson, and H. Levinson, Department of Radiology, St. Luke's Hospital, Milwaukee

A presentation of the indications, techniques, normal and pathologic anatomy of the lymph system which is visualized by means of direct cannulation and injection. Also demonstration by pre- and post-treatment films of Hodgkin's disease, lymphosarcoma, embryonal carcinoma of testicle and lymphedema.

113—CORRELATION OF X-RAY AND SIGMOIDOSCOPIC FINDINGS IN ULCERATIVE COLITIS

Drs. G. W. Sengpiel, R. T. McCarty, J. J. Wallerius, J. F. Wepfer, and A. E. Fitz, St. Joseph's Hospital, Milwaukee

Patients with ulcerative colitis are followed as to the progress of the colitis, by repeated radiological examination of the colon, as well as by periodic sigmoidoscopic examinations. The degree of change (improvements or progression) in the diseased bowel is noted and by correlating the two modes of examinations the significance of the changes is brought out. The exhibit shows the appearance and correlation of these changes in representative cases.

114—ENVIRONMENT AND CORONARY HEART DISEASE

Dr. T. C. Puchner, St. Joseph's Hospital, Milwaukee

Epidemiologic studies settle few questions about mechanisms and final causes of coronary heart disease, but they are producing facts that cannot be ignored if the coronary problem is to be seen in its proper perspective. Debate exists as to why some people, as individuals, are more "susceptible" than others, but the groups who differ in coronary risk can be distinguished epidemiologically. Obviously, young women have less risk than older men. It is also well known that the risk is greater in diabetes mellitus, myxedema, and familial hypercholesterolemia. Illustrations are shown that depict some of the facts based on scientific evidence concerning environmental factors (diet, physical activity, emotional stress) that may be related to cholesterol metabolism and the development of coronary heart disease. These research studies were performed in the laboratory of Dr. Ancel Keyes at the University of Minnesota.

115A—WISCONSIN STATE MEDICAL ASSISTANTS SOCIETY

EXHIBITS AT FOOT OF STAGE

127—FARMERS LUNG

Drs. D. A. Emanuel, B. R. Lawton, F. J. Wenzel, and Charles Bowerman, Marshfield Clinic, Marshfield

Representative case histories of Farmers lung with histopathology and x-ray findings are presented. These cases represent a portion of 24 that have had lung biopsy at the Marshfield Clinic and St. Joseph's Hospital, in Marshfield, Wis. Other diagnostic studies including agar gel diffusion are demonstrated. Therapy and prognosis of the disease are outlined.

128—DIAGNOSIS OF VERTEBRAL LESIONS

Drs. H. C. Hickey and A. J. Jurishica, St. Joseph's Hospital, Milwaukee

The exhibit first points out the need for biopsy in arriving at a definitive diagnosis in lesions of the vertebrae. Then the exhibit brings out the methods available for obtaining biopsy specimens from the vertebrae, and points out briefly the merits of each method. It then illustrates the procedure of vertebral biopsy by the trephine method as to the equipment and the anesthesia used and the technical points to be observed; shows results in few illustrative cases. Then it summarizes the results and points out advantages and disadvantages of this method. A short movie (5 to 7 minutes) will be shown several times during the State Society meeting illustrating the actual procedure of this method of vertebral biopsy.

129—FUNGI PATHOGENIC TO MAN

Drs. Alexander Berman and D. C. Bleil, St. Michael Hospital, Milwaukee

The exhibit presents a classification of fungi and basic information relative to fungi and fungous diseases. Cultures of the common organisms are demonstrated and the particular organism is related to its most characteristic clinical patterns. Where possible, a photograph demonstrating typical features of the clinical disorder produced is shown. The clinical usefulness and mode of action of systemic antifungal agents is noted.

131—PARACERVICAL BLOCK ANESTHESIA IN OBSTETRICS AND GYNECOLOGY

Drs. H. F. Sandmire and S. D. Austin, Green Bay

The exhibit illustrates the use of paracervical block anesthesia in the obstetrical and gynecological patient. With the aid of charts, graphs, and artistic illustrations the technique of administration, advantages of the method, and results obtained in the relief of labor pain with paracervical anesthesia is emphasized. The results obtained in the exhibitors last 100 obstetrical cases is subjected to statistical analysis. Types of gynecological operations which may be performed under paracervical block anesthesia are listed as well as use of the block as a diagnostic measure in patients complaining of pelvic pain. The needle guide, syringes, needles and solutions used are available for demonstration of the technique of administration.

132—CULDOSCOPY FOR DIAGNOSIS

Dr. C. J. Levinson, Milwaukee

A summary of the indications, technique and complications of culdoscopy is presented. Personal cases and pictures are reviewed. A mannikin is used for demonstration of the instrument and technique.

133–134—WISCONSIN HEART ASSOCIATION

Major theme of this exhibit will be "External Cardiac Resuscitation." "Resusci-Anne", a dummy, will be used for practical demonstrations. Films will be shown on "External Cardiac Massage" by W. B. Rouwenhoven, Dr. Ing, James R. Jude, M.D. and G. Guy Knickerhocker, and "Pulse of Life" produced by Archer S. Gorden, M.D., Ph.D., University of Southern California. Literature is available for distribution on this technique as well as other physician educational materials from WHA.

EXHIBITS IN HALLWAY LEADING TO MEETING ROOMS

135—ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

The Association of American Physicians and Surgeons is an organization of physicians which is concerned with the preservation of private medical care and the traditional American free-enterprise system. Educational material and information are disseminated through newsletters, bulletins and meetings to physicians, medical students, interns and residents. Of particular value is background on legislation. An Annual Essay Contest is conducted for high school students. Though AAPS cannot itself engage in political activities, it stresses participation, by individuals, in citizenship matters.

SCIENTIFIC EXHIBITS ON THE STAGE OF BRUCE HALL

A CENTURY OF SERVICE

Milwaukee Hospital Medical Staff

The exhibit by legend, photograph, and illustration portrays the progress and growth of Milwaukee Hospital. It illustrates the parallel growth and advancements in medical art and science during the past 100 years.

MARQUETTE MEDICAL REVIEW

Drs. M. J. Dunn and J. W. Fons, Jr., Milwaukee

TUBERCULOSIS ERADICATION IN WISCONSIN

Wisconsin Anti-Tuberculosis Association

Tells the story of the new concept of TB eradication by means of lighted transparencies and animated panels showing the technique and programs necessary to accomplish eventual eradication.

DIABETES DETECTION IS IMPORTANT

Wisconsin Diabetes Association, Wisconsin State Board of Health

The function of the exhibit is to show the use of postprandial blood sugar in the detection of latent diabetes mellitus. Tests will be given at the exhibit to anyone requesting them. State Board of Health equipment and technicians will give the tests under the supervision of the Wisconsin Diabetes Association.

ORAL LESIONS AND THE USE OF THE ORAL PAP TEST

American Cancer Society—Wisconsin and Milwaukee Divisions, and Marquette University School of Dentistry

There are four 8x10-inch light glass transparencies of oral lesions. Under each of these transparencies there is a brief case history on the lesion. There are also three photomicrographs of pathological slides. A demonstration team of three dental students is available to show visiting physicians the technique of obtaining a specimen. The eight pictured lesions are not all cancerous. Physicians are invited to participate in matching their knowledge against the cancerous and noncancerous lesions by filling out a card and depositing it in a nearby box.

AUXILIARY HOSPITALITY CENTER AND ART SHOW

Be sure you visit the Auxiliary Hospitality Center, have a cup of coffee, and review the various watercolor and oil paintings and sculptures of Wisconsin MDs and their wives. BE SURE TO VOTE FOR THE PICTURE AND SCULPTURE WHICH APPEAL TO YOU MOST!

Be Sure to Watch for Special Mailing on Roundtable Luncheon Reservations

ADMISSION OF NONMEDICAL PERSONNEL

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STUDENTS

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NURSES

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TECHNICIANS

All nonmedical personnel will be admitted to the Exhibit Hall and the Lecture Halls only:

1. If certified by a member.
2. One of these two days:
   Wed., May 8, after 12:00 noon.
   Thurs., May 9, 9 a.m.–3 p.m.

Exhibits close at 3:30 p.m. on Thursday, May 9.

Technical Exhibits

42—ABBOTT LABORATORIES, North Chicago, Ill.
87—AMES COMPANY, Elkhart, Ind.
21—ARMOUR PHARMACEUTICAL CO., Chicago, Ill.
31—AYERST LABORATORIES, Chicago, Ill.

17—ROBERT W. BAIRD CO., Milwaukee
126—BARR X-RAY CO., INC., Milwaukee
64—BENCO OPHTHALMIC LABORATORIES, Milwaukee and La Crosse
44—BEUTLICH, INC., Chicago, Ill.
26—THE BORDEN COMPANY, New York City
121—BREON LABORATORIES, INC., New York City
27—BURROUGHS WELLCOME & CO., INC., Tuckahoe, N. Y.

65—S. H. CAMP & CO., Jackson, Mich.
92—CARNATION COMPANY, Los Angeles, Calif.
70—CIBA PHARMACEUTICAL PRODUCTS, INC., Summit, N. J.

66—DESITIN CHEMICAL COMPANY, Providence, R. I.
122—DICTAPHONE CORP., New York City
46—DIETENE COMPANY, Minneapolis, Minn.

73—EATON LABORATORIES, Norwich, N. Y.
98—EDISON PARK LABORATORIES, Elk Grove Village, Ill.
2—ENDO LABORATORIES, INC., Richmond Hill, N. Y.
35—ERDMAN & ASSOCIATES, INC., Madison

16—A. J. FARNHAM COMPANY, Milwaukee
22—H. G. FISCHER & CO., Franklin Park, Ill.

59—GEIGY PHARMACEUTICALS, Yonkers, N. Y.
1—GENERAL ELECTRIC CO. (X-Ray Div.), Milwaukee
20—GERBER PRODUCTS COMPANY, Fremont, Mich.

85—HANDICABS INTERNATIONAL, INC., Milwaukee
8—HAUG DRUG COMPANY, Milwaukee
117—HOFF CO., INC., Milwaukee
91—HOFFMANN-LA ROCHE, INC., Nutley, N. J.
83 and 84—HURLEY X-RAY COMPANY, Milwaukee

29—KNOLL PHARMACEUTICAL COMPANY, Orange, N. J.
4—KREMERS-URBAN COMPANY, Milwaukee

9—LAKESIDE LABORATORIES, INC., Milwaukee
88 and 89—LANGER LABORATORIES, Milwaukee
74—LA SALLE COCA COLA BOTTLING COMPANY, Milwaukee
3—LEDERLE LABORATORIES (Div. of American Cyanamid Co.), Pearl River, N. Y.
41—ELY LILLY & COMPANY, Indianapolis, Ind.
36—LINCOLN LABORATORIES, Decatur, Ill.
10—J. B. LIPPINCOTT COMPANY, Philadelphia, Pa.
40—LOEWI & CO., INC., Milwaukee
82—LOV-E BRASSIERE COMPANY, Hollywood, Calif.

25—McNEIL LABORATORIES, INC., Fort Washington, Pa.
28—MARION LABORATORIES, INC., Kansas City, Mo.
119—MARSHALL CO., Milwaukee
69—S. E. MASSENGILL COMPANY, Bristol, Tenn.
118—MEAD JOHNSON & COMPANY, Evansville, Ind.
13—MEDICAL ARTS BUILDING CORP., Waunakee
51—MEDCO PRODUCTS CO., Tulsa, Okla.
53—MEDICAL PROTECTIVE COMPANY, Ft. Wayne, Ind.

115—MEDICO-MART, INC., Milwaukee
30—MERCK SHARP & DOHME, West Point, Pa.
63—WILLIAM S. MERRELL COMPANY, Cincinnati, Ohio
60—MID-WESTERN SPORT TOGS, Berlin, Wis.
15—MILEX-ALPHA PRODUCTS, Morton Grove, Ill.
86—MONARCH LIFE INSURANCE COMPANY, Madison
97—C. V. MOSBY COMPANY, St. Louis, Mo.
55—V. MUELLER & CO., Chicago, Ill.

14—NATIONAL DRUG CO., Philadelphia, Pa.

32—ORTHO PHARMACEUTICAL CORPORATION, Raritan, N. J.

68—PACIFIC MEDICAL EQUIPMENT CO., North Hollywood, Calif.
99—PARKE, DAVIS & COMPANY, Detroit, Mich.
94 and 95—PENGELLY X-RAY CORPORATION, Milwaukee
125—PFIZER LABORATORIES, Brooklyn, N. Y.
37—PHYSICIANS & HOSPITALS SUPPLY COMPANY, Minneapolis, Minn.
120—PROCTOR & GAMBLE, Cincinnati, Ohio
6—PROFESSIONAL BUSINESS SERVICE, La Crosse

67—REMICRO SCIENTIFIC INSTRUMENT COMPANY, Milwaukee
116—R. J. REYNOLDS TOBACCO COMPANY, Winston-Salem, N. C.
90—RICHARDS MANUFACTURING COMPANY, Memphis, Tenn.
72—RIKER LABORATORIES, INC., Northridge, Calif.
58—A. H. ROBINS COMPANY, INC., Richmond, Va.
124—ROEMER-KARRER COMPANY, Milwaukee
43—J. B. ROERIG & COMPANY, New York City
71—ROSS LABORATORIES, Columbus, Ohio
96—RYTER CORPORATION, Milwaukee

52—SANBORN COMPANY, Waltham, Mass.
57—SANDOZ PHARMACEUTICALS, Hanover, N. J.
62—W. B. SAUNDERS COMPANY, Philadelphia, Pa.
12—G. D. SEARLE & COMPANY, Chicago, Ill.
11—SCHERING CORPORATION, Union, N. J.
5—SMITH KLINE & FRENCH LABORATORIES, Philadelphia, Pa.
123—SMITH, MILLER & PATCH, New York City
56—E. R. SQUIBB & SONS, New York City
81—STUART COMPANY, Pasadena, Calif.

23—THERMO-FAX SALES, INC., Milwaukee and Madison

38—ULMER PHARMACAL COMPANY, Minneapolis, Minn.
34—THE UPJOHN COMPANY, Kalamazoo, Mich.
80—U. S. STANDARD PRODUCTS COMPANY, Mt. Prospect, Ill.
7—U. S. VITAMIN & PHARMACEUTICAL CORPORATION, New York City

79—W.T.S. PHARMACEUTICALS (Div., Wallace & Tiernan, Inc.), Rochester, N. Y.
78—WALLACE LABORATORIES, Cranbury, N. J.
61—WARREN-TEED PRODUCTS CO., Columbus, Ohio
45—WARNER CHILCOTT LABORATORIES, Morris Plains, N. J.
33—WESTWOOD PHARMACEUTICALS, Buffalo, N. Y.
39—WHITE LABORATORIES, Kenilworth, N. J.
54—WINTHROP LABORATORIES, New York City
77—WISCONSIN 7-UP DEVELOPERS ASSN., Milwaukee, Madison and Oshkosh

93—ZIMMER MANUFACTURING COMPANY, Warsaw, Ind.

RESERVATION FORMS FOR

Roundtable Luncheons • Annual Dinner

NOTE: Attendance Limited! Please List 3 Choices for each of the days you make reservations. List in order of preference. $2.50 per luncheon, including gratuities and taxes.

TUESDAY, MAY 7 (See page 169 for listing)

IMPORTANT: Those making reservations for the Marquette and U. of W. Alumni luncheons please make your reservations as indicated and DO NOT INCLUDE WITH THIS RESERVATION.

1. FERGUSON: ROLE OF KIDNEY IN GOUT
2. HAMMOND: DETECTION OF UTERINE CANCER
3. HAMWI: RECENT ADVANCES IN THYROID DISEASE
4. JULIAN: SURGERY IN CHRONIC OCCLUSION OF FEMORAL ARTERY
5. STARE: DAIRY PRODUCTS IN A DAIRY STATE—OR "TAKING THE BULL BY THE HORNS!"

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice: _____

WEDNESDAY, MAY 8 (See pages 171 and 172 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. LIPCHIK: OBSTRUCTING LESIONS OF LOWER URINARY TRACT
2. GERACI: FEVER OF OBSCURE ORIGIN
3. GLASSY: LABORATORY DIAGNOSIS OF COLLAGEN DISEASE
4. RANDALL: ELECTIVE INDUCTION OF LABOR
5. ROMANO: UNANSWERED QUESTIONS ON "EMOTIONAL CRISES OF PATIENTS AND THEIR FAMILIES"
6. WASSERBURGER: ELECTROCARDIOGRAPHIC PATTERNS IN CHILDREN

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice: _____

THURSDAY, MAY 9 (See pages 173 and 174 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. BAILEY: ORTHOPEDIC AND NEUROLOGICAL ASPECTS OF CERVICAL SPINE INJURY
2. BARONOFSKY: DIAPHRAGMATIC HERNIA
3. BONICA: RECENT ADVANCES IN OBSTETRIC ANESTHESIA
4. E.E.N.T. LUNCHEON FOLLOWED BY SCIENTIFIC PROGRAM
5. KRONFELD: DIAGNOSIS AND TREATMENT OF GLAUCOMA BY PHYSICIANS IN GENERAL PRACTICE
6. MENDELSON: WARTS—PAST, PRESENT AND FUTURE
7. MEYER: PROPER ROLE OF PRACTICING PHYSICIAN IN USE OF NEW DRUGS
8. MORRISSEY: MEDICAL TREATMENT OF PEPTIC ULCER
9. WENNER: CLINICAL USE OF THE MICROBIOLOGY LABORATORY

Name of Leader

First Choice: _____

Second Choice: _____

Name of Leader

Third Choice: _____

ANNUAL DINNER, Wed., May 8

DANCING
SHORT SPEECHES—COCKTAILS

$7.00 PER PERSON
(Including Gratuities and Taxes)

Number Luncheon Tickets ($2.50 each) . . . . . _____ for $_____

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the wisconsin medical journal

VOLUME 62/NUMBER 4 APRIL 1963

Autopsy Incidence of Otitis Media in Infants

By DALE E. VAN WORMER, M. D.
Madison, Wisconsin

SIXTY-EIGHT autopsies performed on infants and children less than five years of age who had died suddenly were reviewed. The autopsy protocol included a description of the middle ears in 29 cases, and there was gross evidence of middle ear disease in 11 (38%) of these. All of these infants were below the age of one year and had either appeared well or had had what were considered to be insignificant symptoms shortly prior to death. In no case had an antemortem diagnosis of otitis media been made.

The information present in the protocols of the infants with otitis media is summarized in Table 1. Four cases of primary otitis, three cases of primary pneumonia with otitis and four cases of sudden unexplained death in which there was an associated otitis media are recorded. In cases one and two the meningitis was demonstrated to have been caused by the same type of organism as that isolated from the middle ears. The otitis media was probably the site of origin of the organisms. In case number three the otitis media was considered to be the probable primary focus of infection resulting in the early bronchiolitis and pneumonitis. Aspiration of stomach contents was a significant finding in two cases. Vomiting may occur in association with acute bacterial disease in infants, particularly otitis media, and this was present to a marked degree in case six. The ages of the 11 infants varied from two weeks to 12 months, with an average of 4.9 months.

The gross appearance of acute or chronic otitis media was confirmed in all 11 cases by a culture made at the time of autopsy and by microscopic examination of a decalcified section of bone taken from the area of the middle ear. Bacteriological examination revealed beta hemolytic Streptococci in two, Diplococcus pneumoniae in four, alpha hemolytic Streptococci in three and Hemophilus influenza in two cases.

Review of the autopsy protocols and all available clinical history in these 11 cases disclosed that eight of these infants had been seen by a physician within three weeks of the time of death. These children were of families to which medical facilities were readily available. Of the four cases in which otitis media was considered to be directly responsible for the circumstances leading to death, two were seen within three weeks, one on the day of death, and one was not seen. The clinical diagnosis of otitis media had not been made in any case, and none of the children were receiving antibiotics.

From Department of Pathology, University of Wisconsin Medical School.

TABLE 1—*Summary of Pathological and Bacteriological Data*

Case No.	Age	Middle Ears	Other Significant Findings	Result of Middle Ear Culture	Comment
1	2 wks.	Acute bilateral otitis	Leptomeningitis	Diplococcus pneumonia	Organism isolated from the brain also Pneumococcus.
2	12 mo.	Acute and chronic otitis	Leptomeningitis	Hemophilus influenza	Hemophilus also isolated from the brain.
3	5 mo.	Acute bilateral otitis	Bronchiolitis and pneumonitis	β-hemolytic Streptococcus	β-Streptococcus also cultured from the lung and blood. Lungs showed early peribronchiolar pneumonia.
4	1 mo.	Bilateral chronic otitis	Acute bronchopneumonia	α-hemolytic Streptococcus	Pneumococcus cultured from the lung.
5	9 mo.	Bilateral chronic otitis	Acute bronchopneumonia	Diplococcus pneumonia	Pneumococcus cultured from the lung. Blood culture negative.
6	2 mo.	Acute bilateral otitis	Aspiration of vomitus	Diplococcus pneumonia	Negative blood culture.
7	7 mo.	Unilateral chronic otitis	Aspiration of vomitus	Hemophilus influenza	Negative blood culture.
8	2 mo.	Bilateral chronic otitis	Pulmonary congestion and edema	α-hemolytic Streptococcus	Negative blood and spleen cultures.
9	4 mo.	Bilateral chronic otitis	Pulmonary congestion and edema	α-hemolytic Streptococcus	Negative blood and spleen cultures.
10	6 mo.	Unilateral acute otitis	Pulmonary congestion and edema	α-hemolytic Streptococcus	Negative blood and spleen cultures.
11	6 mo.	Bilateral chronic otitis	Pulmonary congestion and edema	Diplococcus pneumonia	Negative blood and spleen cultures.

COMMENT

The incidence of otitis media in infants younger than one year is not well documented. It is considered to be a relatively infrequent clinical finding and autopsy information is scanty. In four reported series of sudden death of infants, 62 instances of otitis media were recorded in 195 cases (31.7%).[1-4] Except for two, the affected infants were one year of age or less. It is interesting to note the apparently unchanged incidence since 1947. Although it is difficult to conceive of isolated otitis media as a cause of death, the high incidence recorded in previous reports and the present report would seem to be significant. The difficulties of clinically examining the middle ears of infants make interpretation of the visualized drum a perplexing task. It should be emphasized that the middle ear of small infants is separated from the meninges by only one to two millimeters of the petrous portion of the temporal bone.

SUMMARY

Although statistically significant conclusions cannot be reported on the basis of this study, several facts are evident.

(1) Of the middle ears examined at the time of autopsy in 29 cases of unexpected death in infancy and childhood, 38 per cent (11 cases) showed evidence of acute or chronic disease.

(2) The examination and description of the middle ears should be an integral part of the autopsy in every infant. Only by more extensive studies will it be possible to determine the significance of fluid in the middle ear.

(3) It is apparent that clinically significant otitis media may be overlooked by the clinician, and more diligence should be given to the visualization of the tympanic membrane during the examination of an infant.

1300 University Avenue.

REFERENCES

1. Bowden, Keith: Sudden death or alleged accidental suffocation in babies, M. J. Australia 1:65–72 (Jan 21) 1950.
2. Bowden, K. M., and French, E. L.: Unexpected death in infants and young children—second series, M. J. Australia 1:925–933 (June 30) 1951.
3. Werne, Jacob, and Garrow, Irene: Sudden deaths of infants allegedly due to mechanical suffocation, Am. J. Pub. Health 37:675–687 (June) 1947.
4. Werne, Jacob, and Garrow, Irene: Sudden apparently unexplained death during infancy; pathologic findings in infants found dead, Am. J. Path. 29:633–675 (July–Aug) 1953.

Fetal Distress in Labor

By JACK A. KLIEGER, M. D. and JOHN R. EVRARD, M. D.
Milwaukee, Wisconsin

FETAL DISTRESS in labor is by no means an isolated or an infrequently encountered complication. The magnitude of the problem is suggested by worldwide statistical averages which place the incidence of fetal distress in labor at about 6 per cent.[1] Of the some 4,000,000 babies delivered in the United States annually, approximately 240,000 or one-quarter million will have been diagnosed as having experienced some degree of fetal distress. Of these, 50 per cent will be born dead or die shortly after birth. Many additional thousands will be born alive, but will harbor serious sublethal injuries. Thousands of others will go completely undiagnosed. Ten per cent of all deaths in the United States, from all causes, and in all ages, are perinatal in origin.[2] The most hazardous journey any human being makes during his entire life is the trip down the birth canal, since it is accompanied by a 3 per cent mortality rate. We would never in our wildest dreams elect to take any journey associated with a 3 per cent mortality rate. Depressing and revealing as these statistics are, they are nevertheless understandable for these two reasons:

1. The fetus in distress is so situated that we cannot get at it directly to make a diagnosis, nor can we get at it directly to treat it, but must administer to it through an intermediary, namely the mother. This is akin to trying to manage a desperate case of pulmonary edema over the telephone.
2. Criteria of fetal distress are hard to ascertain. The only way the clinician can evaluate fetal distress is by the clinical evaluation of the heart rate. The reliability of this criterion leaves much to be desired.[3]

Reynolds has pointed out that "physiologic considerations amply attest to the fact that heart rate, so long as the heart is beating, is the least valid measure of cardiovascular function and in no way reflects all the considerations of true oxygen metabolism at a cellular level." Because of the tremendous fetal loss and subtle fetal injuries, as well as the difficulties associated with diagnosis and treatment, we felt it might be useful to discuss some of the cogent features in the etiology and diagnosis of fetal distress, and point out wherever possible some practical considerations in management.

From the Departments of Obstetrics and Gynecology, St. Joseph Hospital and Marquette University School of Medicine.

DEFINITION

The normal fetal heart rate is 120 to 160 per minute. Under normal conditions the fetal heart rate slows moderately during uterine contractions and returns rapidly to normal afterward. Fetal distress in labor is a condition in which the fetal heart rate does not return to normal within 30 seconds after a uterine contraction, or a condition in which the fetal heart rate remains below 100 per minute throughout the interval between contractions.[4] Other clinical features commonly associated with fetal distress are:

1. Increased or decreased fetal heart rates
2. Increased or decreased fetal movements
3. The passage of meconium when the vertex is presenting.

PATHOLOGIC PHYSIOLOGY

Figure 1 is a diagrammatic representation of the feto-maternal circulation demonstrating the umbilical arteries returning blood to the placenta and the umbilical vein carrying oxygenated blood to the fetus. The maternal and fetal circulations are separate and distinct, and while they do not mix, they do come into intimate contact with each other. Anything which may occur to upset this feto-maternal circulatory apparatus predisposes to fetal distress. The cardinal physiologic derangements which may occur are:[5]

1. Placental ischemia (fetal and maternal)

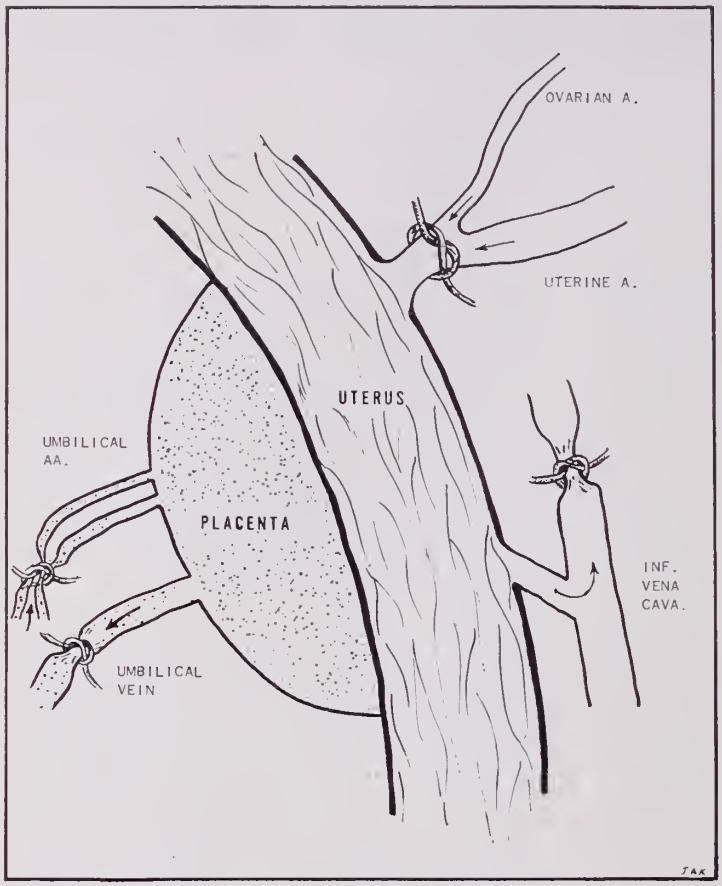

Fig. 1—Diagrammatic representation of feto-maternal circulation.

2. Placental pooling (fetal and maternal)
3. Decreased oxygen tension.

For example, compression of the umbilical arteries from any cause compromises fetal blood flow to the placenta and leads to placental ischemia of fetal origin. Similarly, anything which compromises maternal circulation to the placental site, such as maternal hypotension, or toxemia, leads to placental ischemia of maternal origin. Occlusion of the umbilical vein produces pooling and stagnation of fetal blood in the placenta, just as compression of the inferior vena cava produces pooling of maternal blood at the placental site. In any case the end result is hypoxia and fetal distress.

ETIOLOGY

The specific etiologic factors involved in the production of fetal distress are the story of obstetrics and its complications and are, in descending order of frequency, as follows:

1. *Abnormalities of Placenta and Cord*
   a. Cord complications include:
      (1) prolapse
      (2) knots
      (3) thrombosis
      (The circulation in the cord is compromised and produces placental pooling or ischemia depending upon whether the arteries or veins are occluded.)
   b. Placenta:
      (1) Placenta praevia
      (2) Abruptio placenta
      These common complications of pregnancy are of variable severity but always imply placental separation leading to fetal hypoxia. The profound blood loss frequently associated with these obstetrical complications leads to shock, placental ischemia, and fetal hypoxia.

2. *Dystocia*
   Dystocia from any cause (i.e., malpresentation, breech, fetopelvic disproportion) leads to vagotonia, bradycardia, and decreased cardiac output.

3. *Analgesia and Anesthesia*
   Excessive sedation and the injudicious use of anesthetic agents may produce maternal respiratory depression and/or oxygen deprivation which will be reflected in fetal hypoxia. The maternal hypotension frequently associated with spinal anesthesia produces placental ischemia and will lead to clinically significant fetal hypoxia if sustained.

4. *Excessive Uterine Contractions*
   Excessive, uncontrolled oxytocic (Pitocin) stimulation, or severe tumultuous contractions associated with precipitate labors, contract the vessels of the myometrium

and reduce maternal blood flow to the placental site.

5. *Toxemia and Post Maturity*

Human placental efficiency and permeability decline after reaching a peak at 36 weeks. In post maturity and hypertension from any cause, the maternal blood flow to the placental site may be reduced by one third.[6]

6. *Miscellaneous*

Congenital anomalies, erythroblastosis foetalis, multiple births, as well as the fetal distress potential of infection, radiation, chemical and physical factors are not without their own inherent hazards.

7. *Unknown*

This is an important group for two reasons. First, the diagnosis of fetal distress is never easy, but the difficulties are somewhat minimized by the fact that a clinically recognizable obstetric complication usually accompanies it, calls attention to it, and dictates proper therapy. The treatment of the complication is also in part the treatment of the fetal distress. In this unknown group, the absence of any detectable obstetric complication pointing out the fetal distress makes it doubly difficult to recognize and immeasurably more difficult to manage. Secondly, the infants in this unknown group that are stillborn or die shortly after birth are usually found at autopsy to be perfectly normal, except for the usual evidence of anoxia. Hence the infants in this group would probably be entirely normal if they could be saved.

MANAGEMENT

The management of fetal distress comprises three spheres:

1. Administration of oxygen to the mother
2. Diagnosis of cause of fetal distress
3. Assessment of severity of distress.

1. The administration of oxygen to the mother—first, last, and always—is of paramount importance in the management of fetal distress. Oxygen is transported not only by the hemoglobin in the red blood corpuscles but also in simple solution in blood plasma. While it is true that the administration of oxygen to the mother will not increase the oxygen-carrying capacity of the hemoglobin (and this is the reason some authorities feel that oxygen administration to the mother is useless), it should nevertheless be realized that oxygen administration will increase five-fold the amount of oxygen carried by the plasma.[7] The administration of oxygen to the mother will increase the total oxygen-carrying capacity of the blood by about 10%. Inasmuch as a fetus, even under ideal circumstances, exists in a state of oxygen deprivation (term fetal blood is only 60% saturated), the administration of oxygen in fetal distress requires no further justification, but is mandatory. The fetus in utero is able to derive energy from the metabolism of glucose even in the absence of oxygen; hence the administration of intravenous glucose to the mother is indicated and should be given serious consideration.

2. In the matter of establishing a diagnosis there is no substitute for the time-honored history and physical examination. Sterile vaginal examination may give valuable information regarding the presence or absence of cord prolapse, abruptio placenta, placenta praevia, congenital anomalies, etc. plus definite information regarding the status of the cervix, bag of waters, fetal position, etc., all of which may be useful in directing treatment. An x-ray study, if time permits, is a valuable adjunct in establishing a diagnosis. Parenthetically it should be pointed out that if a Cesarean section is contemplated for purely fetal indications, an x-ray film is exceedingly necessary to exclude the possibility of fetal anomalies. Unless there is an associated maternal indication, operative intervention for an infant already beyond redemption, is hardly justified.

3. Finally, an attempt should be made to assess the severity of the fetal distress. As indicated before, the inability to get directly at the fetus and placenta makes this an extremely difficult task, nevertheless the following observations may be helpful:

(a) Tachycardia
(b) Bradycardia
(c) Irregularity
(d) Meconium
(e) Fetal electrocardiogram

(a) Tachycardia:

Tachycardia may be transitory or sustained. If the tachycardia is transitory

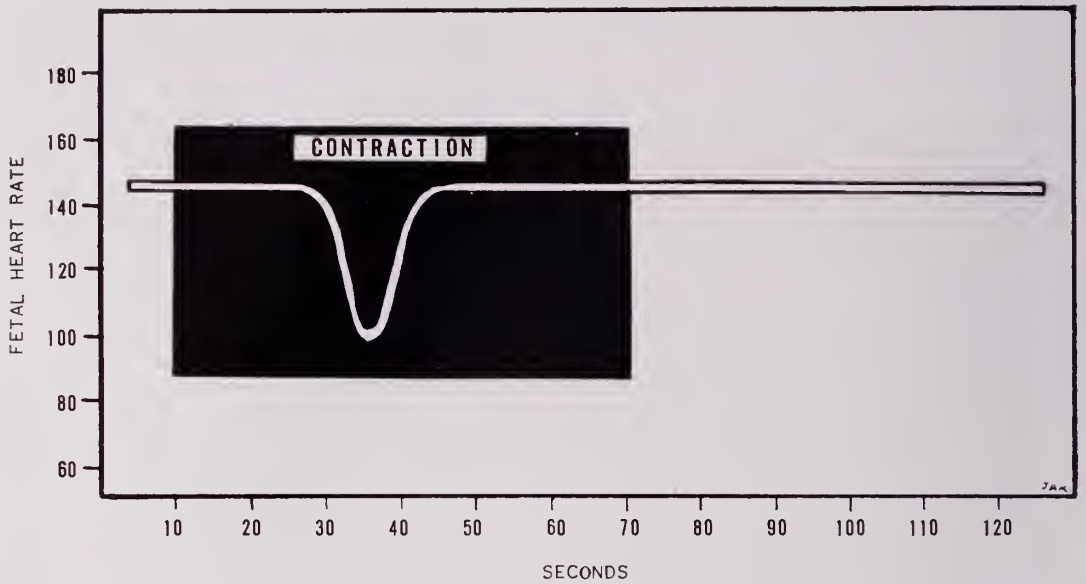

Fig. 2—Normal V-shaped bradycardia due to uterine contraction. Note rapid return of fetal heart rate to normal.[8]

and unassociated with any bradycardia, it is of no significance and does not represent fetal distress. If the tachycardia is sustained it may represent the incipient signs of mild fetal distress, but hardly warrants immediate termination of the pregnancy. Hyperpyrexia of the mother may produce sustained fetal tachycardia and is of no greater significance than the etiology of the fever itself. Sustained tachycardia, however, preceded or followed by bradycardia, represents severe fetal distress and indicates the removal of the fetus from its environment by whatever means appears most safe and expeditious at that time.

(b) Bradycardia:[8]

Figures 2 and 3 represent a diagrammatic simplification of Doctor Hon's investigations. The ordinates represent the fetal heart rate and the abscissae represent the time in seconds. Normally the fetal heart rate decreases during a contraction and rapidly returns to normal giving a "V" type curve. If this bradycardia begins early in the contraction or persists for longer than 30 seconds after the contraction giving a "U" configuration (Fig. 3), fetal distress is present. If the bradycardia is sustained between contractions, serious fetal distress is believed to exist.

(c) Irregularity:

Fetal heart irregularities associated with a normal rate are not significant and probably merely represent ectopic beats. However, arrhythmias associated with bradycardia are representative of severe fetal distress, probably related to myocardial dysfunction.

(d) Meconium:

Passage of meconium, when the vertex is presenting, has probably been overrated as an index of fetal distress. Existing alone and without any other clinical evidence of fetal distress it may indicate mild hypoxia or imply that the fetus is close to its tolerance. If the passage of meconium is associated with bradycardia and/or arrhythmia, the prognosis is less favorable.

(e) Fetal electrocardiogram:

Widening of the Q.R.S. complex and depression of the S T segment have been reported in instances of fetal distress,[9] but not with sufficient consistency to establish the fetal electrocardiogram as an efficient tool in this regard.

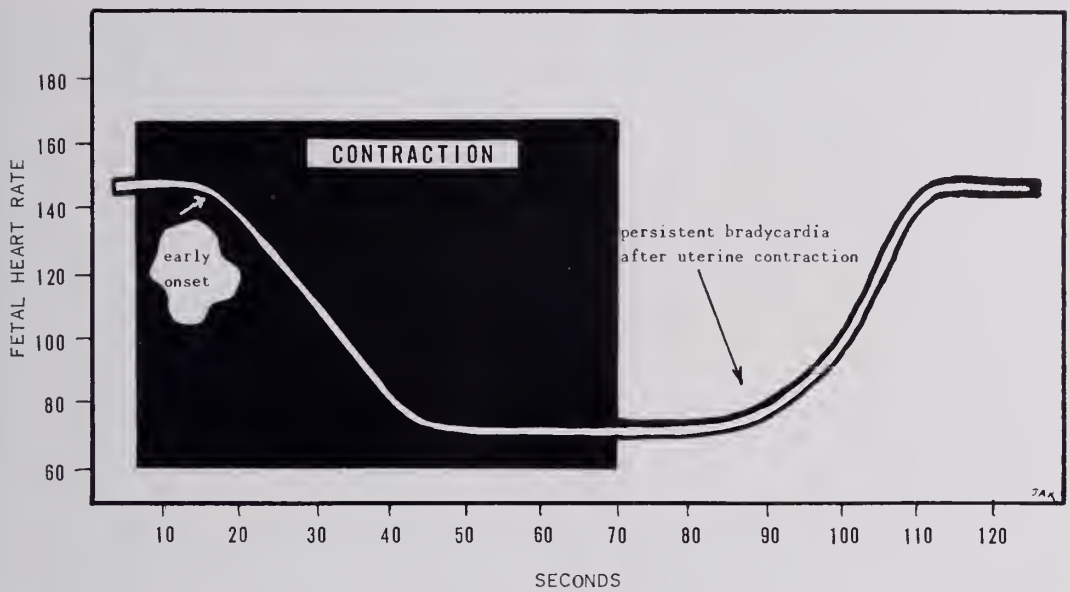

Fig. 3—Fetal distress indicated by prolonged bradycardia after end of uterine contraction.

TREATMENT

The definitive treatment can be summarized as follows:

1. The treatment of fetal distress in labor is frequently the treatment of the obstetric complication producing the distress.
2. On occasion, particularly in the unknown group where no obstetric complication is discernible, the fetal distress, *per se*, dictates the therapy.
3. Oxygen to the mother is of inestimable value to the fetus. The mother's blood is so constituted that maternal hemoglobin gives up oxygen more readily than in nonpregnant patients and fetal hemoglobin picks it up faster. A 10% increase in the total oxygen-carrying capacity of the maternal blood such as is afforded by nasal oxygen, has a marked salutary influence on the fetus in distress.
4. Bradycardia associated with arrhythmias, and sustained tachycardia preceded by, or followed by bradycardia, carry the poorest prognosis and may indicate the termination of pregnancy.
5. Preservation of the homeostasis of the mother is of paramount importance. Hemodynamic preservation and restoration to normal levels is axiomatic. This applies to hypertension as well as hypotension.
6. Glucose solution should be administered to the mother to maintain an adequate supply of glucose to the fetus. The fetus in utero can metabolize glucose even in the absence of oxygen.
7. Placing of the mother in left lateral position removes pressure from the inferior vena cava and prevents placental pooling. This is an ideal position for the delivery of a fetus in distress from any cause.

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REFERENCES

1. Anderson, G. W.: Causes of fetal distress, Clin. Obst. Gynec. 3:823–833 (Dec) 1960.
2. Eastman, N. J.: William's Obstetrics, ed. 12, New York, Appleton-Century-Crofts, Inc., 1961, p. 9.
3. Reynolds, S. R.: Regulation of fetal circulation; its relation to fetal distress, Clin. Obst. Gynec. 3:834–851 (Dec) 1960.
4. Eastman, N. J.: William's Obstetrics, ed. 12, New York, Applcton-Century-Crofts, Inc., 1961, p. 427.
5. Reynolds, S. R., and Paul, W. M.; Pressures in umbilical arteries and veins of fetal lamb in utero, Am. J. Physiol. 193:257–259 (May) 1958.
6. Browne, J. C. Mc., and Veall, N.: Maternal placental blood flow in normotensive and hypertensive women, J. Obst. & Gynaec., Brit. Emp. 60:141–147 (Apr) 1953.
7. Brummelkamp, W. H., Hogendijk, J., Boerema, I.: Treatment of anaerobic infections (clostridial myositis) by drenching tissues with oxygen under high atmospheric pressure, Surgery 49:299–302 (Mar) 1961.
8. Hon, E. H.: Observations on "pathologic" fetal bradycardia, Am. J. Obst. & Gynec. 77:1085–1099 (May) 1959.
9. Larks, S. D.: Fetal electrocardiograms, showing cardiac malformation, including heart block, J.A.M.A. 173: 1217–1219 (July 16) 1960.

Hospital Employee Health Service

WHEN a physician recommends hospitalization, he should be able to do so with confidence that he is sending his patient into a healthy atmosphere. He should be able to feel secure in the knowledge that the staff members who will care for his patient are physically and emotionally able to carry out the responsibilities they are charged with.

A hospital is a place of highly charged emotional factors where physical and mental stability can be a matter of life or death.

Yet, like the proverbial shoemaker's child, the hospital employee more often than not remains shoeless through the lack of an organized and systematic program to help him protect his physical and emotional health.

An occupational health program for hospital employees is a benefit to the hospital, to the physician, to the employee, and above all, to the patient.

The American Medical Association and the American Hospital Association have said: "An employee health service in a hospital is desirable because: 1. There are moral obligations as well as legal requirements—(a) To provide a safe and healthful working environment for employees; (b) to protect employees from special risks associated with contagious disease and other hazards of their occupation; (c) To protect patients from risks associated with unhealthy employees. 2. Hospitals should serve as examples to the public at large with respect to health education, preventive medicine, and job safety. 3. Experience in other employee groups has shown that occupational health services result in healthier, more effective employees, and often reduce absenteeism, labor turnover, and workmen's compensation insurance premiums."[1]

Many Wisconsin hospitals have recognized an employee health service as a compelling need and have requested practical assistance toward this end. As a result the State Board of Health, in early 1962, called upon the Wisconsin Hospital Association, the State Medical Society, and the Wisconsin Nurses Association. Representatives from these organizations formed a joint committee to draw up a general guide for an "Occupational Health Program for Hospital Employees".*

In broad terms, the guide recommends that ". . . .whenever feasible, and consistent with the size of the hospital and to the extent its facilities permit, hospital employees should have their occupational health services offered through a department separate from those for the general public, with emphasis on protection and promotion of health."

The structural organization of a health center would be dependent on the size of the hospital and the scope of the operation. But there are two indispensable factors which the committee feels are essential. They are: (1) the appointment of a physician-in-charge and (2) the understanding, acceptance, and support of the medical staff.

The physician-in-charge (serving usually on a part time basis) should have full department head status. He may be paid by the hospital for this service. Other medical staff, including residents and interns, where available, should participate in the program as needed.

Both the physician-in-charge and the designated head nurse should be appointed on a long-term tenure basis to assure continuity of service and so that employees will associate their health service with specific individuals.

Other personnel, professional and clerical, should be assigned as needed.

The areas of responsibility of the health program as recommended can be divided into four broad classifications:

(1) Estimation of the capacity of the applicant to perform the work; (2) medical preparation of the new employee; (3) maintenance and improvement of employee health; and (4) supervision and control of health hazards in the work environment.

It is emphasized by the committee in the guide that a hospital employee health program should in no way interfere with the patient/physician relationship. Treatment phase of the program should be limited to emergencies, first aid, and temporary palliation. The emphasis should be on prevention. All employees requiring follow-up treatment should be referred to their personal physician.

We all strive for ever-improving medical care, and the hospital phase is not the least in these areas of endeavor. Yet a hospital—like any organization—can be no better than the people who make it up. As summed up by Dr. E. Vincent Askey from the AMA at a Texas Medical Symposium: "Where an employee feels well taken care of himself and where he knows that concern over his own welfare is part of his job, he also will be sure that others will be well cared for and he transmits that feeling to others automatically."—JAMES L. WARDLAW, M. D., *Director, Community Health Services;* and CATHERINE CHAMBERS, R. N., *Occupational Health Nursing Consultant,* State Board of Health, Madison.

* *Author's note:* The complete text of the guide will be available soon through any one of the participating organizations.

REFERENCE

1. Guiding Principles for an Occupational Health Program in a Hospital Employee Group, the *Journal of the American Medical Association,* Feb 15, 1958, and *Hospitals, Journal of the American Hospital Assn.,* Feb. 16, 1958.

Spontaneous Rupture of the Esophagus

By THOMAS E. LYNN, M. D.
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SPONTANEOUS rupture of the esophagus is a serious and often fatal condition unless there is prompt surgical intervention. The onset of symptoms is usually abrupt and almost always related to an episode of vomiting. The most frequent site of rupture is at the inferior end of the esophagus and on the left. Initially, severe lower substernal or upper abdominal pain with associated shock may be preponderant. Diagnostic confusion with more frequently encountered conditions of the thorax or upper abdomen is common. Subsequently the features of mediastinitis, with usually an associated hydropneumothorax, predominate. The fulminating course and high mortality in untreated patients make early recognition and operative intervention urgent.

Case Report. A male, 59 years of age, required emergency hospitalization in the early hours of May 21, 1961. His past history had been that of health. On the evening of the present illness he attended a bowling party and subsequent banquet. Immediately after eating he had an episode of strenuous vomiting which was followed by the abrupt onset of low substernal and upper abdominal crushing sensation. The distress was severe, radiating to the back, and was associated with difficult breathing. He had had no similar episodes in the past.

Examination disclosed a very apprehensive patient with rapid grunting respirations, mild hypotension, and moderate tachycardia. The respiratory rate was 30 per minute. There was marked guarding of the upper abdominal musculature.

The leukocyte count was 3,700 per cu. mm., with 37 segmented forms and 40 band forms. The hemoglobin level was normal. The serum amylase was 225 units and transaminase 60 units. The urine revealed many red blood cells and some white blood cells. An electrocardiogram several hours after admission revealed nonspecific changes with a moderate sinus tachycardia.

Roentgenograms of the chest showed a mild pneumonitis in the base of both lungs, but there was no evidence of a hydropneumothorax

The admitting diagnosis was a spontaneous rupture of the esophagus.

Presented at the fall meeting of the Wisconsin Surgical Society, Sept. 15, 1962, Madison.

Dilute barium swallow 5 hours after admission did not show any extravasation outside of the esophagus. However, roentgenographic studies with diatrizoate methylglucamine (Gastrografin) did show evidence of esophageal disruption. By this time there was a small bilateral hydropneumothorax.

Left lower thoracotomy revealed the mediastinal pleura to be intact. However, there was a large collection of partially digested food surrounding the entire lower esophagus. The food was removed as thoroughly as possible and the area irrigated. A 4 cm. left lower esophageal tear was closed with two layers of chromic catgut. Multiple chest drainage tubes were left to the operative site.

Ten days after admission the patient became more toxic and there was evidence of walled off mediastinal collection posterior to the lower esophagus. Re-exploration was necessary to establish more efficient drainage.

At the time of the second thoracotomy there was a moderate right hydropneumothorax and shortly after the second operation a No. 18 de Pezzer catheter was inserted into the right side of the chest at the level of the eighth interspace in the posterior axillary line.

Subsequently small amounts of methylene blue were given orally and found to drain from both chest cavities. However, the drainage remained adequate and gradually decreased in amount.

He was discharged from the hospital approximately 6 weeks after admission and the chest tubes were removed several weeks thereafter. There continued to be a small amount of drainage from the site of the chest tube wound on the left side for an additional three months. His physical condition contin-

ued to improve and he was able to return to full activity within six weeks after leaving the hospital. He has continued to remain in good health since that time.

Comment. In 1944 Graham[1] described two cases of spontaneous esophageal rupture with survival after surgical drainage of an associated hydropneumothorax. In 1947 Barrett[2] reported the survival of a patient who had an operative closure of the perforation approximately 10 hours after the onset of symptoms. More widespread awareness of the condition has led to an increasing number of reported cases in recent years. If not treated, the condition usually proves fatal. A few patients have recovered without repair of the rupture. They developed a spontaneous pleural cutaneous fistula or had an operative drainage of the involved pleural cavity. There is considerable morbidity associated with such a situation.

It is agreed generally that rupture of the esophageal wall usually results from an abrupt onset of excessive pressure within the esophagus. It is most frequently associated with vomiting. Frequently, there is a preceding excess of eating or drinking.

Factors implicated for the almost consistent rupture in the lower left esophageal wall have included angulation of the esophagus in this area, thinning of the esophageal muscles, entrance of vessels and nerves, and less external esophageal support.[3] Peptic esophagitis has also been implicated as an etiologic factor.[4]

The bursting strength of the intact human esophagus is reduced three times if the mucosa is removed.

The onset is usually sudden and may be so precipitous that some form of poisoning is considered. Characteristically, while retching or vomiting, the patient is abruptly seized with severe pain in the epigastrium or lower substernal area. Not infrequently the vomitus will be blood-tinged or, on rare occasions, frankly bloody.

Rarely the pain may be minimal; but it is generally described as "knife-like" with increasing severity, and is commonly rather refractory to analgesics. Radiation to the back or interscapular region is frequent. The pain is usually aggravated by breathing, and the respirations tend to be rapid, shallow, and grunting in character. Movement generally increases the pain and may make examination difficult.

An attempt to swallow fluid or food usually accentuates the discomfort, and may initiate an episode of coughing if there is a pleural communication. Extreme thirst is a common symptom.

On physical examination the patient appears critically ill. Marked restlessness and apprehension are seldom absent. Some degree of shock is frequently present early, and this becomes more profound with the passage of time. Dyspnea is almost always present, and associated cyanosis is common.

The physical findings in the chest are frequently normal if the patient is examined soon after onset of symptoms. Subsequently, abnormal findings are present, but may be rather variable, depending upon the duration of symptoms and whether a pleural communication is present. Evidence of pleural effusion, pneumothorax, hydropneumothorax, or pneumonitis is often found on physical examination at some time during the course of the illness. Compression of the mediastinum may produce findings compatible with the superior mediastinum syndrome. As the process progresses, subcutaneous emphysema may appear in the neck and spread into adjacent areas. It may be completely absent, but when present is an extremely important diagnostic clue. The continued absence of mediastinal or subcutaneous emphysema suggests a direct perforation into a free pleural space. Initially, tenderness and guarding of the abdominal wall, especially in the epigastrium or upper abdomen, may be the predominant findings. Upper abdominal rigidity is marked on occasion. A diagnosis of a perforated intra-abdominal viscus has frequently been considered.

The differential diagnosis commonly includes coronary occlusion, dissecting aneurysm of the aorta, pulmonary embolism, spontaneous pneumothorax, incarceration of a diaphragmatic hernia, perforated peptic ulcer, acute pancreatitis, and a mesenteric vascular occlusion.

Roentgenography of the thorax is the most valuable laboratory test. Some abnormality will be noted in 90 per cent of cases.[5] The commonest findings are hydrothorax and emphysema of the mediastinum and neck. Even when the process is confined to the mediastinum, a small pleural effusion is frequently evident; and the roentgenographic picture is primarily that of mediastinitis

with a markedly widened mediastinal shadow. The roentgenographic features often precede definitive signs by hours. Not infrequently the roentgenographic findings will initiate consideration of a previously unsuspected esophageal tear. The presence of a massive, rapidly increasing hydropneumothorax strongly suggests a rupture of the esophagus. The hydrothorax may be further complicated by a tension pneumothorax, with considerable shift of the mediastinum to the opposite side. The hydropneumothorax may be bilateral. Pneumothorax with minimal or slow accumulation of fluid is more compatible with spontaneous pneumothorax. Mediastinal emphysema can occur after rupture of a gastric or duodenal ulcer, but almost always there is an associated collection of subdiaphragmatic air. Roentgenographic demonstration of an esophageal fistula with contrast medium confirms an esophageal tear. Aspiration of gastroduodenal contents from the pleural cavity also establishes the diagnosis.

The treatment of spontaneous esophageal rupture consists essentially of a prompt thoracotomy and surgical repair of the esophageal tear. It is also essential to institute adequate drainage of the mediastinal and pleural spaces and maintain comprehensive supportive therapy. The rupture commonly occurs at the inferior end usually within 2 or 3 cm. of the cardia. It is usually a solitary longitudinal slit-like opening. Dark discoloration of the adjacent area from bile and gastric juice is readily apparent. Attempt at closure of the perforation is practically always advisable, even though the condition of the patient is precarious. On the other hand, if the patient has survived the initial days without operative closure, surgical drainage of an involved pleural space may prevent a fatal outcome. When thoracotomy is definitely inadvisable, pleural drainage should be established if the process communicates with the pleural space.

Prior to operation, where feasible, a Levin tube should be passed carefully into the stomach and attached to a constant source of suction. This limits any further extravasation of gastroduodenal contents. The necessity for massive doses of antibiotics, nasal oxygen, and other supportive measures is apparent.

Entrance into the pleural cavity is usually through the bed of the resected seventh or eighth rib. Adequate mediastinal drainage is established at the site of the esophageal tear. The tear is exposed and repaired longitudinally in layers. No attempt is made to close the mediastinal pleura. The pleural cavity is lavaged with a copious amount of warm saline and the thorax closed in a routine manner. An adequate method of external pleural drainage is essential. The more frequently encountered postoperative complications include empyema, mediastinitis, and breakdown of the esophageal repair. The subsequent development of a stricture at the site of the repair is infrequent.

Summary. Spontaneous rupture of the esophagus is an acute surgical emergency. The rupture usually takes place during an episode of vomiting. An element of peptic esophagitis may be a predisposing factor. Initially, severe lower substernal, lower chest, or epigastric pain is prominent. There may be associated upper abdominal tenderness and guarding. Lower esophageal rupture should be considered in the evaluation of an acute upper abdominal syndrome.

The patient appears critically ill, and a moderate to marked degree of shock is common. Within a short time the features of mediastinitis, with or without associated hydropneumothorax, predominate. Their appearance roentgenographically substantiates the diagnosis.

Prompt thoracotomy, with closure of the rupture and adequate drainage of the pleural space, is the treatment of choice. Early recognition and treatment are essential if one is to reduce the morbidity and mortality of this condition.

An example of spontaneous rupture of the esophagus is presented. This patient illustrates certain of the clinical and therapeutic features that have been discussed.

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REFERENCES

1. Graham, E. A.: Editorial comment, Year Book of General Surgery, edited by E. A. Graham, Chicago, The Year Book Publishers, Inc., 1944, p. 382.
2. Barrett, N. R.: Report of case of spontaneous perforation of esophagus successfully treated by operation, Brit. J. Surg. 35:216–218 (Oct) 1947.
3. Derrick, J. R., Harrison, W. H., and Howard, J. M.: Factors predisposing to spontaneous perforation of the esophagus, Surgery 43:486–489 (Mar) 1958.
4. Dorsey, J. M., Hohf, R. P., and Lynn, T. E.: Relationship of peptic esophagitis to spontaneous rupture of esophagus, A.M.A. Arch. Surg. 78:878–888 (Jun) 1959.
5. Bunch, G. H., Jr.: Spontaneous rupture of esophagus, Ann. Surg. 145:1001–1008 (Jun) 1957.

Additional pertinent bibliography is obtainable from the author on request.

THE SATISFACTIONS OF BEING A GENERAL PRACTITIONER

A heavy work load, civic responsibilities, and frequent interruptions of his evenings at home and of his outings with his wife and children cause the family physician to become frustrated and disgruntled with his role in medicine. His dissatisfaction is enhanced when he reads articles, in some medical publications, entitled "General Practitioners—the Vanishing Race," "Should General Practitioners Be Allowed in the Surgical Departments?" and "The Family Physician Is Obsolete"—all of which tend to give readers the impression that the general practitioner is a sub-standard doctor.

But frequently we general practitioners have reassuring experiences. Recently I received a telephone call at 2:00 a. m. from a frightened mother whose four-year-old son had a high temperature of several days duration. Being new in town, she and her husband didn't know any doctor and were calling me upon the recommendation of a neighbor. After several minutes of conversation, I concluded that her son's condition didn't represent a true medical emergency, but it was serious enough from the parents' point of view to justify my making a house call.

Grumbling, I went to their house. The boy was developing a rash typical of German measles, and when I had reassured the father and mother, we went to the living room for a cup of coffee. During our conversation, Mrs. Smith stated that they had just come from a large Eastern city where for each illness they had engaged the services of a specialist. At the time of my call, she thought she probably was pregnant, having missed two periods, and her husband's ulcers were acting up, but they hadn't yet chosen the appropriate specialists to manage those conditions. She then asked me why I was in general practice. After only a moment of stunned silence, I explained that I am interested in *complete family care*—that Stevie's measles could affect Mrs. Smith's pregnancy, as well as disturbing the sleep of both his parents; that Mr. Smith's ulcers could affect the diet and routine of the entire family; and that most important to me was the feeling that the doctor should be a friend to each individual family member, and should make every effort to merit the trust and confidence of the entire family.

Driving home, I was amazed at my feeling of warmth and self-satisfaction, and I was wryly amused that it should have taken a house call in the middle of the night, occasioned by a case of measles, to make me clarify my objectives in being a general practitioner. I then repeated to myself, "May He grant us a quiet night and a perfect end."
—Rex L. Morgan, M.D., *Journal of The Iowa Medical Society*, 52:681 (Oct) 1962.

WHAT ARE LABORATORY TESTS COSTING YOUR PATIENT?

It might be wise for attending physicians to request carbon copies of the bills that the hospital presents to his patients—not as a means of checking up on anyone else, but as a way of reminding himself that everything he asks of the hospital is sure to strike his patient in the pocketbook. Entirely too often the physician is totally lacking in cost-consciousness, in so far as laboratory procedures and therapeutic measures are concerned. Thus, many hospital bills, even for short periods, are astronomical.

Since the majority of patients are covered by some form of insurance, and since utilization determines premiums, the doctor who orders laboratory work with abandon raises costs for everyone who must carry that type of coverage.

In a recent article by Reznikoff and Engle, entitled "The Physician, the Laboratory and the Patient,"* it is emphasized that when ordering laboratory tests, the physician should ask himself the following questions: (1) Is the test relevant and of real value? (2) Is it one of the few tests which are highly specific or pathognomonic? (3) Will the test help in the diagnosis and care of the patient? (4) Is it timely in the present phase of the illness? (5) Are several examinations being requested when one or a few would provide all of the necessary information? (6) Is the procedure one that is characterized by a considerable margin of error? (7) Does the test entail an element of danger to the patient?

Perhaps we are using the laboratory too extensively as a substitute for a carefully taken history and a thorough physical examination. Well remembered is the attending physician of another day who, in making ward rounds, could recognize at a glance that the newly admitted patient had mitral stenosis, aortic regurgitation or pernicious anemia. Trained eyes, ears and fingers are still basic in diagnosis. A carefully taken history frequently establishes the cause of a patient's difficulty.

Before ordering a laboratory test, the physician should give thought to the need for the test, and to its cost to the patient or to his insurance company. A copy of each patient's bill might well deter him from ordering unnecessary or excessive laboratory procedures for the next person whom he attends in the hospital.—*Journal of The Iowa Medical Society*, 52:672 (Oct) 1962.

* Reznikoff, P., and Engle, R. L., Jr.: Physician, laboratory and patient, G. P., August, 1962, pp. 83–86.

CLINICOPATHOLOGIC CONFERENCE

P
C

Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: H. J. DICK, M. D.
Sheboygan, Wisconsin

Drugs, Bugs, and Host

CASE PRESENTATION*

Dr. Henry Winsauer: The patient, a 36–year–old white male, was last admitted to the hospital on July 7, 1961; he subsequently died on Sept. 1, 1961. His chief complaint was purpura for one month with hematemesis, hematuria, and bleeding from the mouth for two days. He also complained of weakness and anemia for three and one–half years; he also had recurrent staphylococcic infections for four years, and an atopic dermatitis for 22 years.

The patient had first been seen in January, 1956, at the age of 31 years. At this time he had chronic atopic dermatitis, particularly on the flexor surfaces of the elbows and knees. This condition had been present since birth. He was one of twins; and his twin had had allergic eczema for the first two years of his life, but since then he had been well. The patient had twin daughters who had had allergic dermatitis. At that time he was treated with local applications and responded. Laboratory returns were within normal limits.

His third hospital admission in June, 1956, was for the same complaint, and revealed in addition a moderate generalized lymphadenopathy and a cataract of the left eye which was considered secondary to his atopic skin disease. Laboratory reports were again within normal limits.

The fourth admission in August, 1956, was because of furunculosis, complicating this dermatitis. Staphylococcus aureus was cultured from these lesions. The organism was found to be sensitive to chloramphenicol (Chloromycetin) among other drugs; and the patient was treated with this for approximately three to four months, on an intermittent regimen.

His fifth hospital stay was from Oct. 25 to Dec. 11, 1956. At that time the physical examination showed red excoriated leathery areas, especially on the face, neck, legs, arms, lower back, and the lower abdomen. On the lower abdomen they tended to assume a nodular formation. There were prominent axillary nodes. Laboratory findings at this time, including the results of several hemograms, were within normal limits. White blood cell counts ranged from 5,150 to 16,450 per cu. mm. with a normal distribution of cells. The eosinophils ranged from 1 to 8%. Other laboratory returns including serum protein, albumin and globulin determination, cephalin flocculation tests, thymol turbidity, and total bilirubin were within normal limits.

Admission number six for the same complaints of furunculosis and atopic dermatitis revealed no change in the physical examination, except for liver enlargement one and one-half fingerbreadths below the costal margin. Extensive laboratory studies were again within normal limits. At this time an alkylating agent in the form of sodium versenate was used; this led to some decrease in pruritus. The seventh admission was again for the same complaints. The only change shown on this admission was eosinophilia of 8 to 12%.

The eighth admission in December, 1957, showed x-ray and clinical evidence of pneumonia in the left middle lung field from which Staphylococcus aureus and Streptococcus hemolyticus were cultured from the sputum. The hemoglobin level was 5.9 gm. per 100 ml., red blood cell count 1,320,000, and white blood cell count 2,250 per cu. mm. Segmented neutrophils were 48%, lymphocytes 50%, stab cells 2%; platelet count was 59,480. The patient was treated with antibiotics and discharged in March, 1958, following 15 blood transfusions which were cross-matched using the Coombs method, and

*From Sheboygan Memorial Hospital.

all of which were uneventful. At the time of discharge the hemoglobin level was 9.7 gm. per 100 ml. and white blood cell count 2,950 per cu. mm. with 42% segmented neutrophils and 2% stab neutrophils. Bone marrow aspiration in January, 1958, showed marked aplasia of all elements.

The ninth admission, one month after discharge, was for staphylococcic infection of the skin. During this time his hemoglobin level ranged from 9.5 to 13.5 gm. per 100 ml. and the white blood cell count remained at a level of 3,000 to 4,000 per cu. mm. Reticulocytes were constant at 1 to 2%. The platelets varied considerably as seen on a peripheral smear. The patient again received nine pints of blood by transfusion without incident. Culture of the abscesses again showed Staphylococcus aureus.

Following this admission he maintained a hemoglobin level fairly well at 10 to 12.5 gm. per 100 ml., but the neutropenia persisted. He had numerous platelet counts which were always decreased, but he never had any bleeding symptoms.

The thirteenth admission was from Oct. 29, 1958, to January, 1959. On admission his hemoglobin level was 12.5 gm. per 100 ml., red blood cell count 4,360,000, hematocrit reading 37%, reticulocytes 1.2%, white blood cell count 2,800 per cu. mm.; mean corpuscular volume was 85, mean corpuscular hemoglobin 29, and mean corpuscular hemoglobin concentration 34. A rare Howell-Jolly body was seen in the stained red blood cells. Platelets appeared decreased on the smear. A differential white blood count of 300 cells revealed neutrophils 22%, eosinophils 3.7%, basophils 0.7%, metamyelocytes 7%, lymphocytes 54.7%, monocytes 7%, unclassified cells 1%, myelocytes 3.3%, promyelocytes 0.3%, and histiocytes 0.3%. The unclassified cells were noted as probably being either lymphocytes or monocytes.

On Nov. 3, 1958, a bone marrow aspiration revealed megakaryocytes of 0 to 3 per low-power field with a differential count of neutrophils 7.4%, eosinophils 2.2%, basophils 0.2%, metamyelocytes 3.2%, neutrophilic myelocytes 6.2%, eosinophilic myelocytes 5%, promyelocytes 2.6%, blasts 2.2%, small lymphocytes 18%, monocytes 0.4%, reticuloendothelial cells 0.6%, plasma cells 1.6%, mitotic cells 1.8%, pathological cells 0.2%, abnormal normoblasts 16.4%, normoblasts 18.6%, abnormal late erythroblasts 6.4%, late erythroblasts 0.4%, abnormal early erythroblasts 2.8%, early erythroblasts 0.8% abnormal proerythroblasts 1.4%, and proerythroblasts 0.6%, and unclassified cells 1.0%.

A Staphylococcus phage type 81 was isolated from the furuncles. Urine porphobilinogen was 0.8 mg., coproporphyrin 3 to 4+, and delta amino levulinic acid 10 mg. per 100 ml. Serum iron was 167 mcgm., gamma globulin 0.86 gm., total serum protein 7.1 gm. (albumin 4.7 gm. and globulin 2.4 gm.), serum calcium 10.2 mg. per 100 ml., phosphorus 3.8 mg. per 100 ml., alkaline phosphatase 9.6 units. Bleeding time and clotting time were normal. Twenty-four hour urine specimen showed normal lead, zinc, and copper content.

The fourteenth and fifteenth hospital admissions were for removal of cataract from the right eye and removal of the left eye in July and December, 1959, respectively. The pathological report of the left eye was chronic endophthalmitis and keratitis, secondary to generalized staphylococcic furunculosis. He was treated with many topical ointments and had one episode of staphylococcic pneumonia which was treated with demethylchlortetracycline (Declomycin) in the spring of 1960. He continued to have treatment with liver, iron, folic acid, and tetracycline (Cosatetracin).

On the seventeenth and last admission in June, 1961, the patient began to develop petechiae, easy bruising, bleeding from the mouth, and blood was found in the urine. At this time his hemoglobin level was 4.6 gm., red blood cell count 1,870,000, and white blood cell count 2,300 with neutrophilic segmented polymorphonuclear leukocytes 32%, lymphocytes 60%, monocytes 8%, and a platelet count of 59,800. A second bone marrow aspiration was performed. A bone marrow culture showed no growth. The bone marrow hematocrit reading was fat layer 2 mm., plasma layer 81 mm., myeloid erythroid buffy coat 2 mm., and red cell layer 15 mm. The differential count on the bone marrow showed lymphoid cells 51%, normoblasts 2%, progranulocytes 8%, segmented neutrophils 3%, neutrophilic bands 6%, neutrophilic metamyelocytes 8%, neutrophilic myelocytes 7%, eosinophils 2%, eosinophilic histiocytes 1%, plasma cells 1% undifferentiated cells 11%.

Physical examination on this admission was essentially the same, showing marked atopic dermatitis with furuncles in varying stages of healing. In addition there were numerous petechiae. Blood pressure was 150/90, the heart and lungs were within normal limits, and the liver and spleen could not be felt. There were a few peripheral lymph nodes. The patient continued to bleed from the mouth and the gastrointestinal and genitourinary tracts. He received numerous transfusions, again without incident. However, he continued to deteriorate. By August the hemoglobin level ranged from 6 to 10 gm. per 100 ml., hematocrit readings 20 to 30 vol. %; the white blood cell count was 1,900 to 4,650 per cu. mm. with segmented neutrophils 21 to 32%, stab neutrophils 12%, neutrophilic myelocytes 16%, neutrophilic metamyelocytes 17%, promyelocytes 11%, myeloblasts 3%, lymphocytes 28%. The patient died on Sept. 1, 1961.

DISCUSSION

Dr. James L. Weygandt: Did he receive chloramphenicol by injection ?

Doctor Winsauer: No, this was oral. He was given full oral dosage from May 23 to 28; again from August 6 to 17 as a hospital patient, and then was continued for an indeterminate period at 250 mg. capsules daily. There was, however, the time interval of approximately 8 to 12 months before the neutropenia developed in the peripheral blood after he had received the chloramphenicol.

Doctor Weygandt: Did he have a septic course?

Doctor Winsauer: No.

Dr. Paul B. Mason: Did he always have furunculosis?

Doctor Winsauer: Yes, the basic dermatitis was always complicated by furunculosis in varying degrees. It never completely cleared.

Dr. Robert M. Senty: Did he have any remissions?

Doctor Winsauer: Yes, he did. Chloramphenicol was given in August, 1956, then he had a hospital admission elsewhere in October to December, 1956, at which time there was no evidence of abnormal neutropenia or leukopenia, or any real degree of anemia.

Dr. Joseph F. Kovacic: Did he receive cortisone?

Doctor Winsauer: Yes, he had considerable amount of cortisone during the admission when he had pneumonia and aplastic anemia. In fact, I think this cured his aplastic anemia.

DIFFERENTIAL DIAGNOSIS

Doctor Winsauer: Here was a patient with a basic chronic dermatologic condition which certainly means to me that this individual had some kind of strange protoplasm. This was an inherited type of condition because it was in the family. In addition there were a number of admissions to the hospital with infection; and after infection—the infection being primarily staphylococcic—there developed an episode of aplastic anemia with pneumonia. This aplastic anemia then went on for approximately one and one-half years. Next, he had two operations with a three-month interval, and there was a normal peripheral blood count with no evidence of anemia and no evidence of neutropenia or leukopenia, although there was a slight lymphocytosis. The last normal blood count was in April, 1960, and following that there was again infection, and finally another hematopoietic and myeloid disease from which he died.

With this brief consideration I thought about the possibility of poor resistance, poor immunity, and therefore considered agammaglobulinemia as a possibility for the recurrent infections. In agammaglobulinemia there must be infection and recurrent infection. This the patient had. There must be normal serum protein; this the patient had. There must be failure of long-term antibiotic treatment; this the patient had. However, we do not have any report of the absence of acquired antibodies; nor do we have a report on the lack of isohemagglutinins in the blood, so we do not know of these two considerations which must be present in agammaglobulinemia or hypogammaglobulinemia. Finally, the syndrome requires absent gamma globulin, and there was one determination made in 1958 in which the gamma globulin was normal. There was no injection of gamma globulin, therefore we do not know whether the patient would have responded with any degree of clinical improvement; however, the diagnosis must be considered here, because there is no definite absence of the gamma globulin, and no laboratory reports concerning the antibodies or the isohemagglutinins.

I did think that it was very unusual and very appropriate that at the time the pa-

tient had his cataract surgery the ophthalmologist recorded that the enucleation of the left eye was made necessary due to an inflammatory reaction, secondary to severe dermatitis with secondary sensitivity of the lens protein. Now this does mean that an individual who has poor skin resistance and who has poor marrow resistance also showed lack of resistance of another organ—the lens of the eye.

Then when he developed pneumonia and aplastic anemia in December, 1957, we found for the first time that the white blood cell count had decreased, the red blood cell count had decreased, the platelet count had decreased, and finally on bone marrow aspiration, there was a hypoplasia of the bone marrow. These are the criteria in aplastic anemia and these were present in this patient. He had a pancytopenia and anemia. As to the etiology of the aplastic anemia, the most frequently discussed cause is the ionizing radiation or x-radiation; because most cases have developed following this. There is no history that this man had been exposed to ionizing radiation. There is no history that this man had been given an unusual amount of x-ray therapy to his skin at any time. It did not seem that it might have been a familial aplastic anemia such as a Fanconi's disease because there were no other congenital abnormalities other than the skin; therefore, this does not fit into a familial aplastic anemia which is seen in Fanconi's congenital pancytopenia.

There is also an aplastic anemia associated with thymoma. There is a very interesting relationship between thymomas and the adrenal axis, and it is usually found that there is an anemia in a thymoma. This anemia may be or may not be associated with a neutropenia or a thrombocytopenia. However there had been innumerable chest x-ray films, and there was never any report of mediastinal change; therefore, this cause of this aplastic anemia may be dismissed. There is also an idiopathic type. There is a myelophthisic type of aplastic anemia which is an infiltration or replacement in the bone marrow due to neoplasm, granuloma, or fibrous disease. We have no evidence on bone marrow studies that these changes had occurred; therefore, this is not a myelophthisic type of aplastic anemia. An iso-immune hemolytic anemia with myelotoxic effect could produce this aplastic anemia in the face of a pneumonia, but the negative Coombs reaction certainly does not make it fit into the iso-immune hemolytic anemia with myelotoxic effect.

I believe this aplastic anemia was due to myelotoxic agents, and I offer the consideration that the recurring constitutional infections of the Staphylococcus producing the furunculosis was probably the cause of this severe aplastic anemia. Drugs could also do it, and chloramphenicol is one that has been reported. This does not occur frequently but it is very serious. Chlortetracycline can also do this. It is one of the 50 on the American Medical Association's list of drugs which can produce an aplastic anemia in a sensitive individual. Certainly this patient had large doses of chlortetracycline and also for some time before his pneumonia was given chloramphenicol. As you know, alkylating agents such as sodium versenate or nitrogen mustard, and the folic acid antagonists such as dimercaprol (BAL), all produce aplastic anemia. In order to treat a neoplastic disease this type of anemia in a mild degree is produced in an attempt to control the neoplastic cells. Finally, there are industrial volatile poisons, but there is no history in this man that would incriminate any of the benzenes producing aplastic anemia.

The third phase of this case was the return to an apparently normal hematopoietic system with no evidence of anemia, no evidence of neutropenia or thrombopenia, after 28 blood transfusions and high doses of adrenocorticosteroids. This continued for some months, and probably the multiple transfusions and the adrenal steroids were responsible for this improvement. There is one other drug that was not used and which is very effective in this type of aplastic anemia or some of the myeloproliferative types of anemia. That is the androgenic steroid, testosterone, in its varying forms. This should be kept in mind along with the steroids as a very essential part of the treatment, because there have been isolated cases of remarkable improvement in this type of anemia with androgens and steroids.

Finally, there was the development of purpura and pancytopenia. The purpura new, the pancytopenia again similar to that when he had his aplastic anemia. This was his final hospital admission. The bone marrow

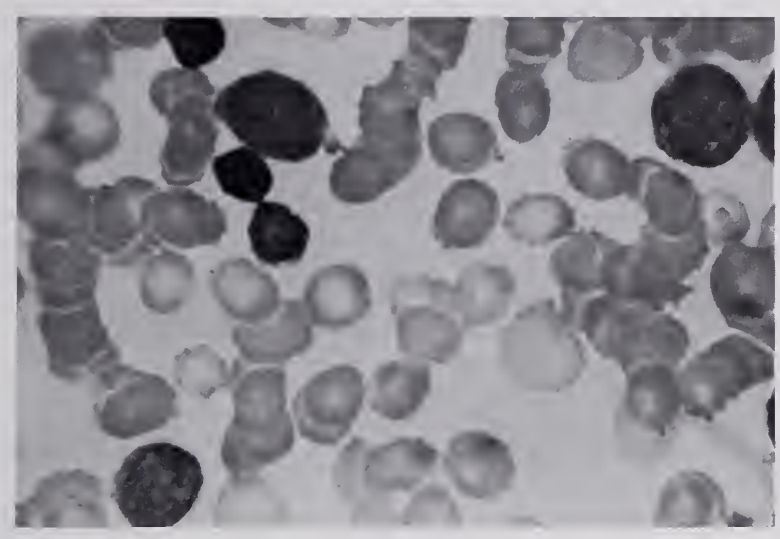


Fig. 1—Buffy coat of the last bone marrow aspiration (June 1961) showing the peculiar "blast" like cells. (Wright's stain X970).

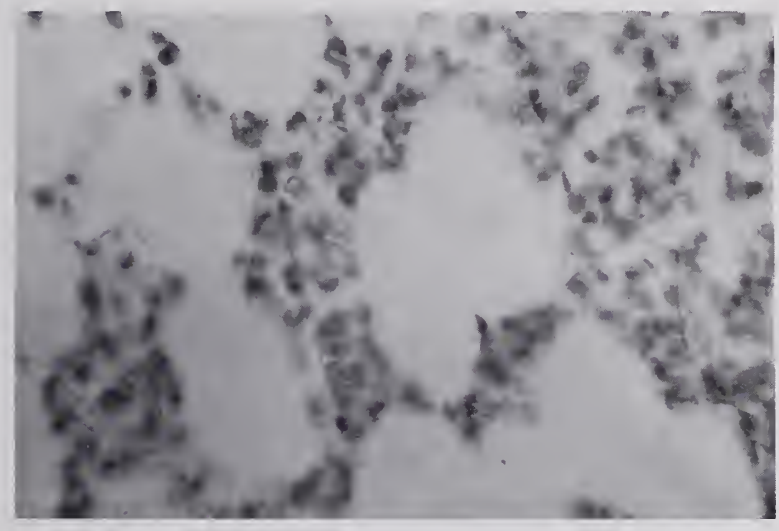


Fig. 2—Bone marrow fragment from aspiration (June 1961). It is very fatty with relatively few bone marrow cells. (Hematoxylin and eosin X430).

again became hypoplastic, and the hematopoietic elements disappeared. There was an increase in the lymphoid and hematopoietic cells which were all young atypical promyelocytes and others of that variety. The aplastic anemia with the abnormal juvenile elements was also part of this pancytopenia. Later, the peripheral blood, near the terminal stage, showed continuing anemia with slight increase in the total white cell count, but many abnormal young granulocytic series cells which might be pathological or tending to be neoplastic.

So in conclusion, I feel this is a complicated case of *bugs* of pathogenic and toxic character; an illness characterized by a constant variety of *drug* treatment, and an individual, who as a *host* began with a dermal and likely constitutional inherited defect. The modern armamentarium of treatment probably led to a long enough disease process so that the myeloproliferative aspect may be an aplastic anemia, bone marrow hypoplasia, which by way of myeloid metaplasia terminated in a neoplasia, a leukemia.

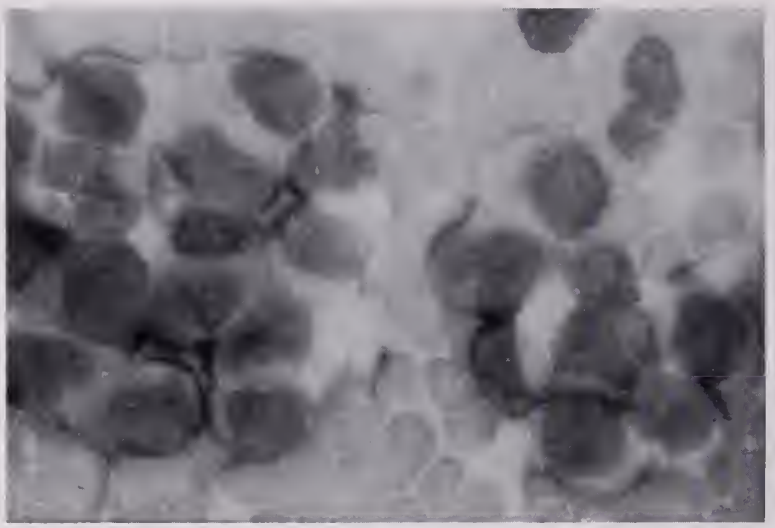


Fig. 3—Peripherol blood, three doys before deoth (August 28, 1961), showing myeloid or monocytoid cells which resemble those found in sections of the bone morrow ond spleen. (Wright's stoin X970).

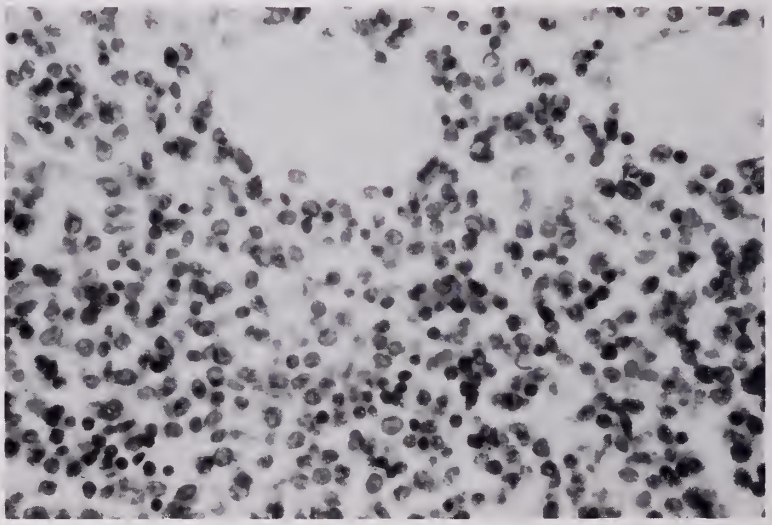


Fig. 4—Bone marrow from the outopsy (Sept. 1, 1961) showing a very much more cellulor morrow, almost entirely promyelocytes or promonocytes. (Hematoxylin and eosin X430).

Dr. H. J. Dick: I realize that there have been a great deal of laboratory findings presented. This represents about one-fourth of what I found on the record. By way of explanation, the first bone marrow aspiration was not available for re-examination; and I do not know what is meant by abnormal normoblasts and some other abnormal cells. Essentially the figures given were consistent with an aplastic bone marrow. The other laboratory studies during that admission showed that apparently porphyria was considered. However, all the laboratory studies to diagnose porphyria were again normal. Doctor Jaeck might want to discuss the bone marrow aspiration which he did.

Dr. J. L. Jaeck: My impression of the last marrow biopsy, with tongue in cheek, was aplastic anemia and possibly aleukemic leukemia.

AUTOPSY FINDINGS

Doctor Dick: At autopsy the essential gross findings were a borderline-size spleen of about 250 gm. The liver weighed about 2,000 gm. There were the petechiae and the skin lesions as described in the clinical abstract. There were also petechiae in the pelvis of the kidney and in the mucosa of the stomach from which he had apparently bled fairly briskly. Microscopically, there was a rather marked increase in cellularity of the bone marrow, most of which were of the myeloid series, especially as compared with the small piece of bone marrow which we had from the last bone marrow aspiration in June, 1961. So far as the other organs were concerned, they were entirely within normal limits except for small areas of hemorrhage; and except for the spleen in which there was infiltration with myeloid type cells, although there was not total distortion of the architecture as would be seen in the typical classical leukemia. My opinion on this is like Doctor Jaeck's, with tongue in cheek. This man died, and the autopsy showed what I think is a rather early case of leukemia. Now as how this long story of aplasia of the bone marrow fits in, I think all we can say is that such cases have been described. There are numerous so-called myeloproliferative syndromes which start as one thing and end up as another. I think if we call this anything, we probably must call it a long period of preleukemic myeloid leukemia and perhaps a rather short course of a very acute myeloid type of leukemia.

Dr. James D. Michael: Were phosphatase determinations or stains done on peripheral blood or bone marrow? I believe that that is of help in differentiating myeloid leukemia from leukemoid reactions.

Doctor Dick: Yes, that can be done, either on a buffy coat or on the smear. I could not find any record that that had ever been done.

REFERENCES

1. Meale, J. B.: Aplastic Anemia; Myeloproliferative Syndromes in Laboratory Medicine, Hematology, pp. 627–649.
2. Block, M., Jacobson, L. O. and Bethard, W. F.: Preleukemic acute human leukemia, J.A.M.A. 152:1018–1028 (July 11) 1953.

FOUR APPROVED MEDICAL ASSISTANT COURSES IN STATE BY SEPTEMBER

Wisconsin now has three approved courses for training medical assistants, with the fourth such course to be added in September. Each of these courses is approved by the Wisconsin State Medical Assistants Society and endorsed by the State Medical Society of Wisconsin.

The first course of this kind was offered in 1960 by the Milwaukee Institute of Technology. It is a two-year course and its graduates receive a degree in "Associate in Applied Science." In 1961 a one-year course was started in Madison at the Vocational, Technical and Adult School. A similar one-year course was begun last September at the Sheboygan Vocational, Technical and Adult School. The fourth course will be started in Green Bay in September, 1963.

Since the initial establishment of these medical assistant courses, enrollments have shown a healthy increase and the number of applications indicates a growing educational interest in this field of medical office personnel.

Candidates are carefully screened on the basis of aptitudes, interest and academic ability. Students are taught such things as medical ethics and etiquette, medical terminology, assisting with physical examinations, sterilization, simple laboratory methods, medical shorthand and dictation, telephone techniques, processing of insurance forms. A period of on-the-job experience is provided each student prior to graduation.

Qualified members of the Wisconsin State Medical Assistants Society and members of the faculty at any one of the schools welcome the opportunity to speak at Career Day Programs at high schools in the state.

Information concerning these courses and available student graduates can be obtained by contacting Mary Vick, R. N. of the Milwaukee Institute of Technology; June Tyler, R. N. of the Madison Vocational, Technical and Adult School; Ruth Vinson, R. N. of the Sheboygan Vocational, Technical and Adult School, or; Violet Owen, R. N., Education Chairman of the Wisconsin State Medical Assistants Society, 631 W. South Street, Stoughton. MRS. ALEEN PIEPENBURG, Waukesha.

SHORTAGE OF GAMMA GLOBULIN

The supply of gamma globulin for distribution to physicians by the State Board of Health has been exhausted, according to word from Josef Preizler, M. D., Director, Bureau of Communicable Diseases.

The Red Cross allotment for July has already been distributed and additional supplies of gamma globulin are not expected until late summer.

Doctor Preizler said the high incidence of measles in the State in the past five months (29,000 cases) created a demand for gamma globulin that resulted in the depletion of the supply available to the State.

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

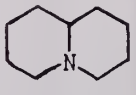
Sparteine* — A New Oxytocic Drug

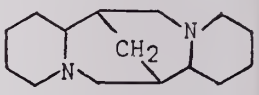
By ALBERT C. YARD, M. D., Ph. D.
Milwaukee, Wisconsin

EDITOR'S NOTE: In the September 1962 issue of the Wisconsin Medical Journal, page 439, Dr. John R. Evrard, chairman of the Division on Maternal and Child Welfare, Commission on State Departments of the State Medical Society of Wisconsin, published a letter which was addressed to the Chiefs of Staff of Wisconsin hospitals. He stated that because of the potential danger of ruptured uterus if sparteine was improperly used, it was advised that hospital staffs apply the same rules for its use as in the use of other oxytocics.

■ WHEN DRUG therapy is utilized for induction of labor or as part of the management of uterine inertia during labor, the agent used is nearly always oxytocin (Pitocin). Although oxytocin is highly effective, it is such an extremely potent substance that great care must be exercised in its use. It should be administered as a dilute solution in 5% dextrose in water by means of a slow intravenous infusion according to most authorities. Such intravenous infusions need to be carefully supervised by medical and nursing personnel so that excessive uterine stimulation is avoided. Failure to regulate the dosage of oxytocin properly can result in an undesirably rapid rate of progress through the first and second stages or in the production of uterine contractions that are strong and continuous rather than rhythmic. These difficulties have not been reported in the literature dealing with the clinical use of sparteine, thus making it unnecessary to provide the moment to moment control over dosage offered by an intravenous infusion.[1] Sparteine can be administered intramuscularly and the patient receiving it need not be the object of continuous supervision.

Sparteine is not truly a new drug, but an old one for which this new use as an oxytocic has been suggested. It is an alkaloid which belongs chemically to a large group called the lupin alkaloids which are characterized by the presence of the quinolizidine ring. Sparteine can be extracted from a very large number of plants and shrubs found in this country as well as abroad. The empirical formula for sparteine was determined in 1851; in 1933 the structure was established; and in 1936 the following structure consisting of four saturated rings was verified by synthesis of the compound.





The pharmacological properties of this compound have not been exhaustively studied, and although it has received sporadic attention, it is not included in most of the current textbooks of pharmacology. The reason for this probably is the fact that sparteine was initially recommended for the treatment of certain cardiac arrhythmias. It was found to be much less effective than digitalis or quinidine and was therefore largely abandoned. Scattered reports of animal experiments indicate that large doses of sparteine can exert a quinidine-like action on the heart, depressing conduction and contractility. Other investigators have established that large doses in animals can cause ganglionic and neuromuscular blockade.

* Sparteine sulfate is marketed under the tradename of Tocosamine by Trent Pharmaceutics, Inc., New York City.

Lower doses possess the ability to induce or augment uterine contractions in many species, the stimulant effect on rate and amplitude of contraction being greater in the gravid than in the nongravid uterus. These observations provided the basis for evaluation of sparteine as an oxytocic in the human.

The first report concerning the oxytocic effect of sparteine in humans appeared in 1939, in which a beneficial action of sparteine was claimed in cases of uterine inertia. Subsequent clinical reports have tended to confirm the contention that this drug can shorten labor whether given as treatment for inertia or for induction. More significant, however, is the fact that the drug has had fairly broad trial in obstetrics during the past five years and no report of tetanic contraction of the uterus has appeared to date nor has there been any suggestion that sparteine influences the incidence of maternal or fetal complications.[2] Because the duration of action of sparteine is short, it has been found to be less effective than ergonovine in treating postpartum uterine atony.

While it appears that sparteine may be a useful drug with an advantage in convenience over oxytocin, it has not been demonstrated to be more effective. There is a need for more carefully controlled evaluation in comparison with oxytocin to provide quantitative comparative information. Similarly, there is a need for more adequate information about the basic pharmacology of this drug with respect to dose-response relationships, metabolism of the compound, therapeutic index, and especially the mechanism of action.

REFERENCES

1. Gray, M. J., and Plentl, A. A.: Sparteine; review of its uses in obstetrics, Obst. & Gynec. 11: 204, 1958.
2. Plentl, A. A., Friedman, E. A., and Gray, M. J.: Sparteine sulfate; clinical evaluation of its use in management of labor, Amer. J. Obst. & Gynec. 82: 1332, 1961.

TRICHLORETHYLENE, TRILENE®, TRIMAR® ANALGESIA IN OBSTETRICS

Q ***Trichlorethylene analgesia via a Duke® inhaler is used for deliveries in our hospital. On occasion the nurse holds the mask, especially during the delivery and episiotomy repair. Is this safe?***

A Trichlorethylene, Trilene® and Trimar® are three names for the same chemical compound that is a useful analgesic drug in obstetrics.

As an analgesic agent trichlorethylene may be *self-administered* following instruction by a physician or nurse familiar with the drug. A number of special inhalers have been designed to facilitate safe self-administration, the best known being the Duke University Inhaler. The safety of self-administration lies in the fact that the inhaler falls from the grasp if unconsciousness (anesthesia) supervenes; and with administration discontinued, the patient awakens. Trichlorethylene inhalers should not be applied by a person other than the patient whether that person be a nurse, an aide or someone else, even under the personal supervision of a physician. The Duke University Inhaler was designed for safe self-administration *only*, and for *analgesia*, not anesthesia.

In the pamphlet that is enclosed with the drug by the makers of Trilene, the following statement appears in *capital letters* and *bold-faced type* in a separate *block* with the *underscored* heading, IMPORTANT—*TRILENE®* ALONE IS NOT RECOMMENDED FOR ANESTHESIA NOR THE INDUCTION OF ANESTHESIA. This statement is repeated in the text of the pamphlet, again in capital letters.

Clearly, the obstetrician should not request a nurse to hold or support the trichlorethylene inhaler for any patient. The nurse should refuse to apply the trichlorethylene inhaler to a patient, regardless of who issues the order.—WILLIAM KREUL, M.D.

EDITOR'S NOTE: The above was prepared at the request of the Maternal Mortality Study Committee of the Division on Maternal and Child Welfare of the Commission on State Departments of the State Medical Society of Wisconsin.

American Board of Obstetrics and Gynecology

Applications for certification in the American Board of Obstetrics and Gynecology, letters requesting reopening of applications, and requests for re-examination are now being accepted in the office of the Executive Secretary. All applications and letters of request must be submitted by July 1, 1963, and accompanied by *current* duplicate lists of patient dismissals for the preceding twelve months. —ROBERT L. FAULKNER, M.D., Executive Secy-Treas, American Bd. of OB & GYN, 2105 Adelbert Road, Cleveland 6, Ohio.

THE PRESIDENT'S PAGE . . .

The Value of Quality

■ IT SEEMS DESIRABLE that physicians in practice hold office in their medical societies, since they are the ones who really know the problems of the doctors at the grass roots . . . those who are in practice in their communities.

So the young men starting to practice who cannot spare time because of financial problems, or the demands of a young family, or any other reason should keep their county and state officers and delegates informed of their opinions and local problems. Activity in the PTA, the School Board, their Church, helps to keep track of current attitudes in the community. These are the people who need and pay for our services. If their attitudes toward the physician, medical care, and legislation reveal lack of understanding, it is because we have failed to present our case locally. We can be more convincing to our patients and our neighbors than professional speakers representing national organizations.

In regard to legislation, it seems to me too many people and too many legislators are preoccupied with the cost of medical care to such an extent that they exclude and disregard the value of quality in medical care.

This present furor over the cost of medical care overshadows more pressing problems such as the distribution of physicians, more applicants for medical schools, and the conservation and preservation of our present physician population.

Some individuals only partially utilize their medical education for the benefit of society. A few never use it either in practice, teaching, or research. Facts about such losses from the medical profession could be of great value to the admission committees of medical schools. A medical education is too long, too expensive, and the facilities too limited to allow for avoidable waste of valuable medical educational opportunities.

The funds available to local and state medical societies are limited. But even a limited project combining the preservation of the health of our members, together with facts from their careers after graduation could provide information of untold value for the future. Conceivably, a radical change in admission policies and postgraduate education might justifiably follow.

(continued on page 206)

the WISCONSIN MEDICAL JOURNAL
Published Monthly

APRIL 1963
Vol. 62 No. 4

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Serious Shortage

■ THE SHORTAGE of family doctors has become so urgent that even President Kennedy has included plans to relieve it in his national health program. The very statement of this sad fact is an indictment of the orientation of present day medical schools, including those in our state, which turn out more specialists who leave the state to practice in metropolitan centers than it does general practitioners who return to their own communities.

Nobody can be forced into general practice under any system. If the advantages of specialization are so great, a medical student would have to take leave of his intelligence to select a career of general practice. Yet the very existence of specialists implies a corps of general practitioners to care for the sick and to refer to the specialists those cases that merit specialized attention. This pattern of medical care has been seriously jeopardized by the fact that the glamour of a specialized practice, not to mention the convenience and monetary rewards, outweigh the community service values of general practice. Unless something is done soon, not only will the availability of medical care be threatened—the situation to which the president was referring—but also, just as seriously, more and more people will attempt to diagnose their own ailments and pick out an appropriate specialist to consult.

The American Academy of General Practice has been aware of the problem and has, through its project MORE, been trying to interest capable students in careers in medicine. But the potential of such a program is limited; after having stimulated an interest in medicine in a teenager, the trick is to keep him interested in a general practice after he gets to medical school.

Real progress, on the other hand, has been made by the Kansas University School of Medicine, which has assumed the burden of responsibility of providing family doctors for Kansas. The Kansas program is dedicated to training of physicians for practice in Kansas. Preceptorships, general practice graduate training programs and postgraduate courses give prestige as well as educational support to the young doctor who might be inclined to a general practice. As a result, the AAGP reports that "a measurably higher percentage of KU students do, in fact, enter general practice."

Lip service to the idea of producing more general practitioners is common—and mostly futile. The key to the problem appears to be through the pocket book. In Kansas the emphasis on education for general practice *in Kansas* received strong financial support from the state legislators, and the philosophy of training physicians for general practice became an educational practice.

In Wisconsin we must examine the experience of other states in implementing programs of training family doctors. It is well to articulate the need for doctors who will stay in their own communities, but it is more important to take action to change the attitude of our own medical schools in this respect. The problem should be brought to the attention of our own state senators and representatives, to make sure they understand how the taxpayers' money could be used for the service of residents of the state.

—D. N. G.

COMMENTS FROM THE PRESS

Chief Argument for Aged Care Isn't True

The principal argument behind campaigns to provide medical care to everyone drawing social security benefits is that most of our elderly population is in dire financial straits. Like many another premise in propaganda campaigns, this one has a big hole in it—it isn't true.

One study disproving the premise was conducted by the University of Michigan. It finds that the bleak portrait of near poverty among the aged is based entirely on income and ignored such vital elements as family relationships, debts, assets, tax advantages and other factors. These put aged families in a favorable position as compared with younger families. Specifically, it is found in 1960 the median value of total assets held by families whose head was past 65 was $8,349. This is almost twice as much as the $4,839, which was the median value of total assets of all other age groups.

So far as medical care is concerned, it was learned that 96 percent of aged families—and 90 percent of all other families—did not owe a physician, dentist or hospital. And only one percent of those who had such debts owed $500 or more. The study further revealed that in the area of personal debt, including installment debt, the aged are substantially better off than younger people.

This, of course, does not mean that the aged need no help, in medical or other affairs. Many do, and they are receiving and should receive that help. Existing systems of aid are constantly being improved and extended. But it does show that vast exaggerations have been and are being promulgated in the effort to saddle the nation with an enormously costly, inefficient, and unnecessary means of dealing with the problems that exist.—Reprinted from the *Waukesha Daily Freeman*, Dec. 4, 1962.

THE PRESIDENT'S PAGE *(continued from page 204)*

It seems to me that the efforts of organized medicine in regard to chiropractic, optometric, and the psychologist legislation as well as to King–Anderson and similar socio-economic legislation has one common and fundamental purpose: To Preserve the Continuing Quality of American Medicine.

This may be over-simplification to a certain extent, but to me it is basic, and I fear it is either forgotten or overlooked by our elected officials in their search for votes to continue to keep them in office. To us, as physicians, the desire to continue the quality of American medicine is so taken for granted that we do not realize the need to keep repeating this precept to the new generations.

N. A. Hill, M.D.

the wisconsin medical journal

VOLUME 62/NUMBER 5 MAY 1963

Cytology—A Community Service

By PHILIP G. PIPER, M. D.
Madison, Wisconsin

■ DIAGNOSTIC exfoliative cytology today, provides a realistic mechanism that can be utilized by the practicing physician to control cancer on the community level. Since the important clinical and diagnostic observations of Doctor Papanicolaou, the cytologic smear technique for the diagnosis of neoplastic disease has grown and flourished. Now, in addition to the cervical smear, other areas of the body have been included in cytodiagnosis, such as the lung, stomach, prostate, and rectum. Although the latter areas of the body have shown promise as far as smear diagnosis is concerned, the growth of vaginal cytology during the past 10 years has been phenomenal. Yet, much remains to be done in exploring the possibilities of more effective means of screening as well as developing the community services. The pathologist and physician must constantly work together toward this end.

Horn reported that of every 10 adult women in the United States, 4 had never heard of the vaginal cytology examination. Of the remaining 6 who had heard of it, 3 had had the examination at least once, and 3 had never had an examination by cytologic means.[1] Horn also stated that in 1960 approximately 5,100,000 women were analyzed by "PAP" smears in about 1,700 laboratories.[2] From the anticipated increase through public education, this number could be doubled without difficulty over a short period of time. Such an increased volume would require additional cytotechnologists, laboratories, and pathologists trained in the field of cytology to provide an adequate and useful service to the physicians in their respective areas.

In order to meet the expanding demands, it has become evident that the three main areas of concern are with the problems of supply and demand. First, the total female population, second, the local physicians providing a service to the community, and finally, the pathologist and cytotechnologist who are responsible for the interpretation of the smears. In order to meet this ever-growing demand, the following areas are being studied and improved. At present in the United States there are about 65 approved schools for cytotechnology. Development of new schools is being considered, and the recruitment of cytotechnologists has been stepped up. Training in cytopathology has become a part of all approved residency programs in the field of pathology. Postgraduate education of the pathologist in cytopathology has become essential. The manner in which this has been accomplished has been by individual study in his own laboratory, the

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attendance of national cytology seminars, and short courses in established training centers throughout the country. By these means, improved techniques are established and a thorough study in areas other than uterine and cervical can be included as a part of the pathologist's experience.

Establishment of Local Cytology Services. If, for the purposes of this paper, we accept the premise that schools, cytotechnologists, and the pathologists will increase to supply the demand, a more fundamental and basic problem presents itself to us; namely, the establishment of local cytology services to meet the respective requirements of each community and a study of how this can be accomplished. There are essentially three approaches to this problem. The first would be an independent laboratory under the directorship of a pathologist who employs full-time cytotechnologists for adequate mass screening. These independent laboratories would have to provide kits and mailing containers for the referring physicians, and the service would have to be based on accuracy and speed and equipped to handle a large volume community service. The second method would be through hospital laboratories in which the cytotechnologists and pathologists could provide not only a service for the inpatients but also for an ever-expanding outpatient need. Such a service would have to be available, not only to the immediate attending staff of the respective hospital, but also to physicians not on the staff who might wish to refer their cytology preparations to this laboratory. Finally, the establishment or the expansion of already existing large cancer detection centers should be considered. This latter means, although instrumental in establishing the value and accuracy of the "PAP" technique for mass screening, has resulted in increased growth far beyond expectations, thereby exceeding their useful limits for adequate laboratory controls, follow-up, and personal contact with case studies.

Criteria for Community Service. Needless to say, the *modus operandi* for a local facility must be decided upon by the physicians in the area and by the pathologist who is to provide the service, whether it be through a hospital laboratory, a group of hospital laboratories, or a private cytology center. Regardless of the means to the end, the following criteria are essential for a satisfactory community service.

1. It must provide kits, slides, and fixatives with a mailing card large enough to contain basic information for adequate interpretation of the smears. This information should include the patient's name, age, marital status, and pertinent clinical data such as the date of the last menstrual period, the description of any gross lesion, any previous cytology reports, the hormonal status of the patient, radiation history, and a surgical history.
2. There should be adequate follow-up and confirmation of all smears that are abnormal, with frequent conferences between the pathologist and referring physician. Through such contacts, better quality control of the cytology service can be established.
3. Complete records should be maintained in any laboratory, at least beyond the statutes of limitations for the state in which the laboratory is set up.
4. A satisfactory method of billing should be provided.
5. Free service to all indigent patients should be available.

Dane County Cytology Center. In Dane County a cytology center has been set up. It represents an example of a community solving the problem of meeting the ever-growing demands for an adequate cytology service. The basic concept for a community cytology service was established through the cooperation of Dr. A. S. Evans, the Director of the State Laboratory of Hygiene, local pathologists representing the private hospitals in the area, and the County Medical Society. It became apparent, through study as a joint effort, that in our immediate area a central laboratory would expedite the needed service, and it would eliminate the necessity of reduplication of personnel in multiple private hospital laboratories. For this reason an independent private laboratory under the directorship of the pathologists from the three private hospitals in Madison was established. The next important step was to obtain support of the County Medical Society through a vote of the active membership for such a cytology program. A cytology coordinating committee was established in the Dane County Medical Society. The purpose of this committee was to

work with the local pathologists in establishing the anticipated needs that could be met through the central laboratory. After the needs were established, the pathologists developed a laboratory which would supply all the physicians of Dane County with mailing containers, fixative, slides, and data cards which met the U. S. postal regulations, since the post office and the telephone are the two successful routes of communication for such a program. The above material was supplied to each physician according to his needs. As the material was received in the laboratory, it was processed and the report was sent to the physician's office by return mail. All suspicious and positive cases and in many instances presumptive cases, which caused some concern as far as interpretation of the cytology, were discussed with the referring physician by telephone. The service was made available to all physicians, irrespective of hospital affiliations, and was made free to all indigent patients under their care. A procedure of direct billing to the patients was set up and proved very satisfactory.

Annually all of the atypical, suspicious, and positive cases were followed up by letter and by phone call, and a complete correlation with biopsy and surgical procedures was made. Such a study included the total number of atypical smears, suspicious smears, positive smears, number of in situ lesions identified by smear, number of invasive lesions identified by smear, and the total number of false smears. At the end of the first year of operation, there were follow-up and confirmation on 94 per cent of the cases studied by the laboratory that had been reported atypical, suspicious, or positive. Our results were compared with the national statistics in other laboratories, along with a complete review of all cases that were reported as false. Such a follow-up and complete study with a review of biopsy material by our pathologists in the local hospitals offer the best criteria for laboratory quality control because the establishment of well-kept records in this type of facility is a most adequate means of providing a complete service. The annual tabulation of statistics was then sent to the Cytology Committee of the Dane County Medical Society. A copy also went to Doctor Evans to compare with the statistics from this area which had been previously supplied by his laboratory. After 12 months of operation 19,600 smears had been reviewed.

The laboratory personnel consisted of trained cytotechnologists who acted as the agents for the pathologists and, in turn, both worked together as a team for the referring physicians and their patients. Our method of reporting consisted essentially of negative, atypical, suspicious, and positive smears. All atypical, suspicious, and positive preparations screened by the cytotechnologist were checked and confirmed by the pathologist. It was found that a competent full-time cytotechnologist could handle 40 smear preparations per day. The actual number, however, depends upon the aptitude, background, and training of the cytotechnologist. The relationship between the pathologist and referring physician requires frequent communications by phone, complete understanding of the terminology, and a real desire to help each other help the patient.

Expansion Program Needed. No matter how or by what competent method, cytology must be expanded in all areas of our state. This can be done by accentuation of lay education, development of still more responsibility by the referring physician, increasing the number of approved schools for cytotechnologists, emphasizing cytotechnologist recruitment, and an accentuation of the pathologist's interest in Cytology Screening Centers. By these means we, the physicians, can establish a service suitable to the needs of any community in our state with the utilization of a technique which has become valuable in the early diagnosis of cancer.

Summary. A brief review of the methods of the establishment of Cytology Centers according to the needs of the community has been discussed. Special reference to the *modus operandi* of a specific private laboratory in Dane County was made.

925 Mound Street (5).

REFERENCES

1. Horn, D.; Clinical Cytology and the Pathologist, Workshop on Cytology, C. A. P., and A. S. C. P., Am. Ca. Soc. Pub., 1962, pp. 9–10.
2. Horn, D.: Clinical Cytology and the Pathologist, Workshop on Cytology, C. A. P., and A. S. C. P., Am. Ca. Soc. Pub., 1962, pp. 12–13.

CYTOLOGICAL SCREENING FOR UTERINE CANCER THROUGH PHYSICIANS' OFFICES

In the Sept. 20, 1958, issue of *The Journal of The American Medical Association*, Doctors Paul Calabresi and William D. Stovall of Madison reported on 65,163 women examined over a period of 10 years (1947–1956), by the cytological technique. The vaginal smears were taken by local physicians in the course of an office visit, in predominantly rural areas, and completely on the "mail-order" basis. Over 9,000 patients returned for repeat screenings.

A progressive fall in yearly prevalence rates for all malignancies was observed. This was believed to be an indication that more physicians in the state were using this test on asymptomatic women, rather than on those with suspected lesions as in the earlier years. The total number of smears increased progressively.

Reporting as an atypical finding the presence of normal glandular cells in smears of postmenopausal women may be of assistance in improving the detection of adenocarcinoma of the endometrium.

False-positive reports, if measured by negative biopsy diagnosis, were at most 9.3 per cent. Seven hundred and fifty neoplasms were detected by vaginal smear. The relationship of in situ to invasive carcinoma is an important problem. The authors' data was consistent with the concept that the intraepithelial lesion is an early stage in the development of invasive epidermoid (squamous cell) carcinoma of the cervix.

TAMPON METHOD FOR MASS SCREENING TO DETECT CARCINOMA OF CERVIX UTERI

In the November, 1955, *Journal of the American Medical Association*, Doctor Madeline J. Thornton from the Department of Obstetrics and Gynecology, University Hospitals at Madison, presented the results of a survey using the tampon method. A group of 2,059 patients was screened for the cytological detection of carcinoma of the cervix uteri by means of the Draghi detection tampon. Of these, 758 patients had the tampon left in the vagina overnight, while 1,301 had the tampon in the vagina for a shorter period of time, ranging from ten to forty–five minutes. Some problems were encountered due to the lack of knowledge on the part of the patients in the use of tampons. However, when patients returned for periodic examinations, it was not necessary to repeat the instructions the second time. Of the 2,059 patients screened by the tampon method, smears from 1.2 per cent had malignant cells present, 0.3 per cent were regarded as suspicious, and 1.36 per cent contained Trichomonas. All patients found to have malignant cells were established as cancer by biopsy.

One hundred forty-seven patients were screened by the use of the detection tampon who had dilatation and curettage and/or biopsy of the cervix, and there was correlation of the biopsy and the cytology in 90.5 per cent. There was a discrepancy between the biopsy and the cytology in 9.5 per cent with a negative cytology and a positive biopsy in 7.48 per cent.

The author concluded that the use of the Draghi detection tampon was a satisfactory method for obtaining smears for the mass screening of patients for the cytological detection of carcinoma of the cervix uteri. Since in 7.48 per cent of those patients in whom it was possible to compare the smear and a biopsy, there was a negative smear and a positive biopsy, it seemed advisable that several smears at relatively frequent intervals on the same individual might reduce this figure.

Although the article was published in 1955, Doctor Thornton has stated in 1963 that the tampon method is still used for mass screening by some communities and large industries.

APPENDICITIS AND PREGNANCY

King, Ruth M. and Anderson, Gail V.; Department of Obstetrics and Gynecology, University of Southern California, and Los Angeles County Hospital, Los Angeles, Calif. *California Medicine* 97:158 (Sept.) 1962.

In a study of 56,000 deliveries and 18,000 nonterm pregnant patients admitted, there were 36 cases of acute appendicitis. Twenty-nine of these were ante partum, and 7 were within six weeks of delivery.

The chief complaint was pain in the upper abdomen shifting to the right lower quadrant and associated with anorexia, nausea, and vomiting. The majority had rebound tenderness, right-sided tenderness on rectal examination, and decreased bowel sounds. One fifth of the patients had a normal leukocyte count.

Once the diagnosis was made, appendectomy was performed. Antibiotics were given preoperatively in all cases of suspected rupture.

There was one maternal death. This patient had a ruptured appendix, widespread peritonitis, and developed acute tubular necrosis with uremia.

Two appendectomies were performed in the first trimester. Both delivered normal infants at term. Six of the 11 patients who had appendectomies while in the second trimester and 7 of the 16 in the third trimester had premature deliveries. Sixty-two per cent of these occurred during the first four postoperative days. The fetal mortality was 17 per cent (five infants).

The differential diagnosis includes: (1) pyelonephritis, (2) twisted ovarian cyst, (3) round ligament syndrome, (4) ectopic pregnancy if the patient is in the first trimester, (5) threatened premature labor or abruptio placenta if the patient is in the last trimester, (6) salpingitis, and (7) labor pains.

Prompt diagnosis and surgical therapy will be rewarded by a high percentage of success.

Present Status of Services for Cervical Cytology in Wisconsin

By ALFRED S. EVANS, M. D.

Madison, Wisconsin

■ ALL WOMEN over 20 years of age should be examined every one or two years by means of the cervical cytology test of Papanicolaou for the early detection of cancer of the female genital tract. This principle is widely accepted by private practitioners and public health physicians alike. The examination should be a part of the routine examination of every female. In essence this is a public health procedure and must be widely available to all the citizens of Wisconsin at low cost. The expansion of existing facilities and the development of new ones such as community cytology centers should now be carried out to provide the widest application of this important test. We have within our grasp the tools necessary to eliminate deaths from cancer of the cervix. This paper will review the present status of cytology services in Wisconsin, including the availability of local services, and raise questions on the mechanisms which might be desirable for expansion in the future.

Materials and Methods. The data on the number of pathologists, cytologists, and the number of specimens examined in private hospitals and clinics in the state is derived from two questionnaires sent out by the Wisconsin Society of Pathologists, one of them in conjunction with the State Laboratory of Hygiene. One survey was carried out in 1960 and one in 1961.*

The data from the State Laboratory of Hygiene from 1947 to 1956 is derived from an analysis made by Calabresi, Arvold, and Stovall.[1] Data from 1956 to 1960 has been derived from monthly reports of the State Laboratory of Hygiene and from a Federal survey program. Data in 1961 has been obtained from a punch card system in which four months have been sampled and from this yearly estimates have been made.

Certain limitations of this data should be emphasized. Since 1956 the total number of smears examined is known, but the number of repeat examinations on the same woman is unknown. The total percentage of women over 20 years of age examined will be somewhat exaggerated on this account. The female population over 20 years of age has been derived from the 1960 census data published by the State Board of Health. In summary, the methods employed do not permit highly accurate tabulation of actual numbers, but they do give trends and comparisons that are of importance.

Present Status of Cytology Services. The importance of cervical cytology as a public health procedure for the early detection of cancer has been widely recognized and promoted by the United States Public Health Service and by state health departments. In Wisconsin educational and service programs have been carried out by the Division of Cancer Control of the State Board of Health and through the State Laboratory of Hygiene which is the official public health laboratory for the State Health Department.

Public health facilities for cancer diagnosis were initiated in August 1947. At this time specimens were received largely from women who had clear-cut symptoms, and a screening program of well women was not attempted. In 1956 Dr. W. D. Stovall, Director of the State Laboratory of Hygiene, in cooperation with Dr. A. L. Van Duser, Director of the Division of Cancer Control of the State Board of Health, initiated a screening program of well women in 14 counties, mostly rural. This study was sponsored by the National Cancer Institute of the National Institutes of Health to deter-

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Doctor Evans is Director of the State Laboratory of Hygiene, Wisconsin State Board of Health.

* The Wisconsin Society of Pathologists has permitted use of the results of these questionnaires in this paper.

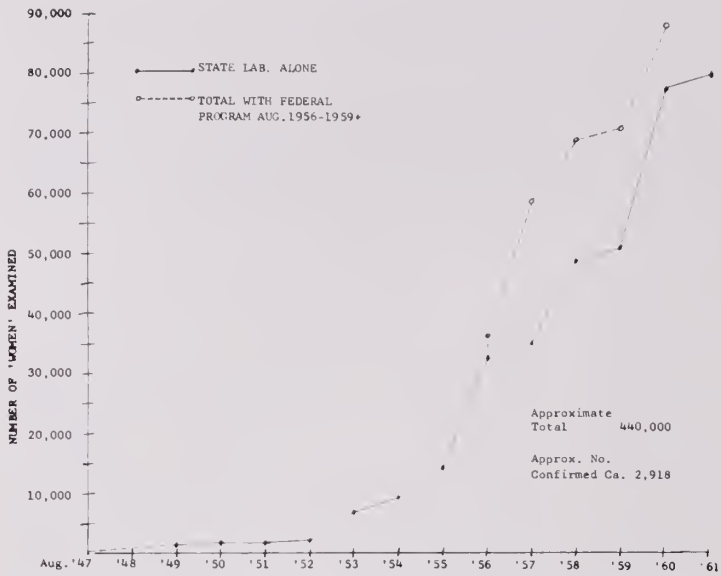

Fig. 1—Number of women examined by cervical cytology in the State Laboratory of Hygiene 1947–1961, including the federally sponsored screening program from 1956–1960.

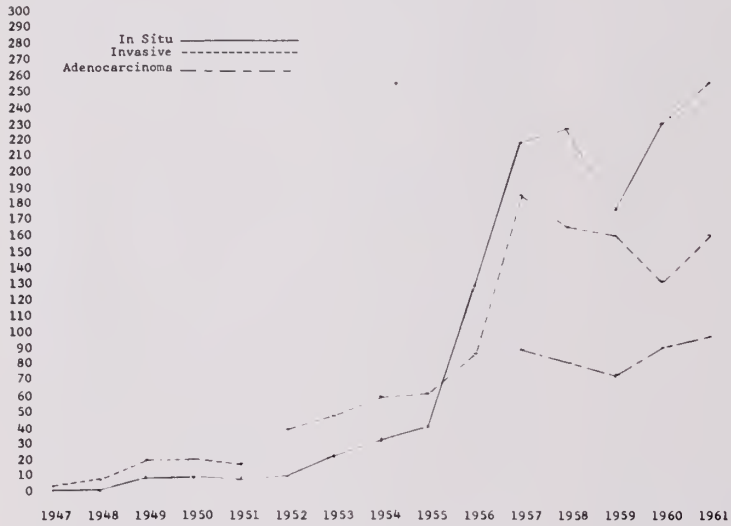

Fig. 2—Number of cervical and uterine cancers detected by cervical cytology in the State Laboratory of Hygiene 1947–1961.

mine the significance of repeated smears on the same woman and extend the feasibility of this test as an office collection procedure with mailing for analysis in a central laboratory. In addition to this, the regular cytology services of the State Laboratory continued to other areas of the state and the emphasis shifted from diagnostic cytology to the screening of asymptomatic women. An estimate of the total number of women examined is given in Figure 1. From 1947 until 1956, a total of 65,163 women had been examined, and 804 confirmed malignancies had been discovered by cervical cytology.[1] From 1956 through 1959, both the regular State Laboratory program and the special screening survey were in operation as indicated by the double line. The National Institutes of Health program terminated in January 1960 and it was not possible to secure additional support either from the Federal government or from the State government for its full continuation. Despite this, efforts were made to provide continuing service not only to physicians in the 14 counties in the survey but also to the state as a whole. In Figure 2 the total number and type of cervical and uterine carcinomas diagnosed has been indicated. In the 14 years of operation of the cytology services of the State Laboratory of Hygiene, almost 3,000 confirmed malignancies have been found. The results of the special cancer demonstration program in the 14 county areas are given in Table 1 to emphasize the extent to which an intensive promotion campaign can successfully screen a large population. Approximately 60 per cent of the 120,000 female population over 20 years of age were examined and 40,000 of these had at least one repeat examination: 1.5 per cent were found to have abnormal cervical cytology, and uterine cancer was established by biopsy in 414 of these, or 0.61 per cent.

During the time of the promotion of these services by the State Board of Health and the State Laboratory, private laboratories were initiating cytology services. These were mostly in Milwaukee and a few widely separated hospital and medical centers. During recent years the increased

interest of physicians in this procedure has resulted in the establishment of a number of local cytology centers scattered throughout the state. The present status of cytology from these private sources as well as from the State Laboratory of Hygiene in 1961 is summarized in Table 2. Of the 72 counties, 44 had cytology services available locally while the rest did not. There were 45 cytotechnologists in the state in 1961. Examinations for cervical cancer were carried out on approximately 176,000 women which represents 14.4 per cent of the female population over 20 years of age. Approximately half of these specimens were examined in the State Laboratory of Hygiene and the other half in private laboratories. Most private cytology was centered in Milwaukee County which contributed almost half of the total number of private examinations performed, which emphasizes the need for the development of more extensive local facilities in other areas. It is also estimated that about two times the present number of women could be examined if existing local facilities were utilized to the maximum.

The pattern of development of private cytology services has varied from one area to another. In the City of Milwaukee the services have primarily been centered in hospitals and have been directed at the attending staff of that particular hospital. In other cities such as in Appleton, Stevens Point, and Wausau, efforts have been made to provide cytology services through a centralized laboratory available to all physicians of that community. A third pattern of development has been the provision of services to a whole county through cytology centers. This pattern is seen in Racine, Kenosha, Eau Claire, Brown, Dane, Rock, and Winnebago counties. In all of these areas the State Laboratory of Hygiene has encouraged the physicians to support and utilize such local facilities.

The geographic location of cytotechnologists and private cytology services in the state is shown in Figure 3. This shows that most cytology centers are in the larger urban areas and that many parts of the state are still not covered by private laboratory services. There are approximately 90 hospitals in the state in which cytology services are available and 35 of these have one or more cytotechnologists as screeners. Forty-five of the private hospitals or clinics providing cytology services indicate that they have or could provide mailing containers to the physicians of their area to send in specimens. This means that physicians not in the immediate vicinity of the hospital might be able to use a nearby local service through the mail yet be close enough for a close follow-up and liaison with the pathologist. This development could come through the cooperation and sponsorship of cytology centers by several county medical societies adjoining a central laboratory.

The geographic distribution of cytology services in Wisconsin is given in Figure 4. The black bar indicates the county distribution of cytology services carried out in private laboratories based on reports from a laboratory survey. The white bar represents the percentage done in the State Laboratory based on the county of residence of

TABLE 1—*Cancer Demonstration Program in Wisconsin, August 1956 to January 1960*

Area Included	14 Rural Counties
Female Population Over 20 Years of Age	120,000
Total Women Examined	71,000
Number of Repeat Examinations	40,000
Total Examinations	111,000
Abnormal Cytology	1084 (1.5%)
Uterine Cancer By Biopsy (within 60 days)	414 (0.61%)

Site	No. Cases	Suspected (%)	Silent (%)
Cervix			
In Situ	253	7	93
Invasive	113	36	64
Adeno	5		
Corpus Uterus			
Adeno	48	40	60
Vagina			
In Situ	3		
Invasive	2		
Labia	2		
Urethra	1		
Ovary	2		
Others	9		

TABLE 2—*Cytology Services in Wisconsin, 1961*

Survey Conducted by Wisconsin Society of Pathologists and State Laboratory of Hygiene

I. Counties Responding to Survey (Total of 72)	72
A. Counties *with* cytology services	44
B. Counties *without* cytology services	28
II. Total Number of Cytotechnologists (C.T.)	45
III. Total Number of Examinations Performed	176,365
A. Number at Hygiene Laboratory	84,608
B. Number in private laboratories	91,757
IV. Present Potential	346,000
A. Total Population of Wisconsin	3,952,765
B. Females over 20 years old	1,222,434
C. Per cent examined last year	14.4
V. Future Potential, C. T. Students	10/year
A. Increase per year (examinations)	50,000
B. Number of years to meet requirements for examination of present female population over 20 years old every year	21

Fig. 3—Location of private laboratories and cytologists in the state. The dotted line indicates that the laboratory director provides coverage in more than one place.

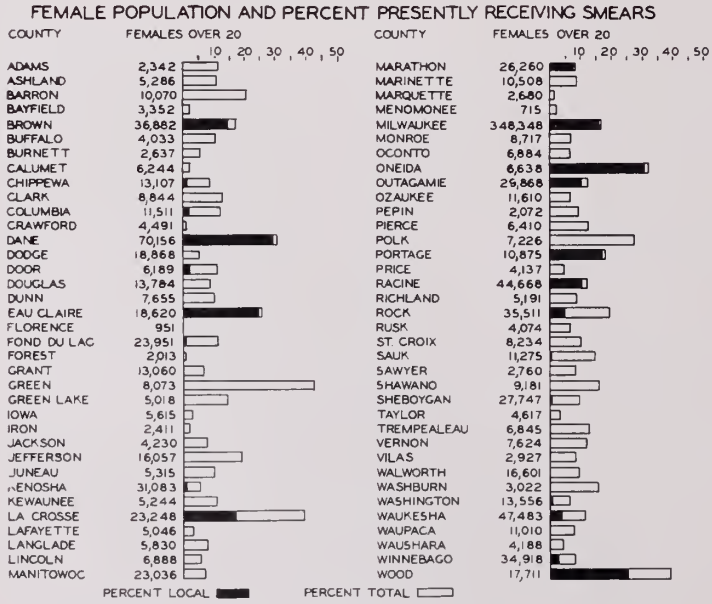

Fig. 4—Geographic distribution of cytology services in Wisconsin.

the submitting physician. The graph indicates the extent to which local laboratories are providing service as compared to the public health laboratory. The absolute percentage of women examined in each county is unreliable because of the way the basic data was obtained. This results in over-estimation of the percentage in urban counties with large medical centers and under-estimation in rural areas.

On a national basis physicians and public alike are becoming increasingly aware of the importance of cervical cytology as the most important practical method of detecting early cancer of the female genital tract. In a recent Gallup survey 58.7 per cent of the women over 21 years old questioned were aware of the Papanicolaou smear test for uterine cancer. A nationwide survey of cytology facilities in the country was conducted by the American Cancer Society and reported in the May–June issue of *CA* of 1961.[2] According to this survey, at least 5,100,000 women were screened by this test in 1961, or about 10 per cent of the adult female population in the United States. In Table 3 selected statistics from the largest states are compared with those of Wisconsin. According to this estimate Wisconsin is among the first three or four in providing cytology to its population. Katz reported recently from a survey of state laboratories that five were offering some type of cytologic services to physicians.[3] In New York State they are offered to supplement local cytology services in areas without approved laboratory facilities as well as to certain public hospitals and institutions.

Training Facilities. A school for cancer cytologists is operated at the State Laboratory of Hygiene under the sponsorship of the State Board of Health and the Department of Preventive Medicine of the University of Wisconsin. Funds for support of the school and of the trainees is provided by the Cancer Control Division, Bureau of State Services, U. S. Public Health Service, and the Wisconsin Division of the American Cancer Society. Eight candidates are accepted yearly with entrance requirements of two years of college and completion of 12 credits in science. Candidates receive a stipend of $225 a month for a formal training period of six months. At the end of six months there is an additional six months of practical training either in the State Laboratory of Hygiene or in cytology centers with a large volume of cases which are designated by the school director. Presently funds are available for four trainees in support of this six months of practical training and the other four must be supported by the institutions in which their practical training is completed or from other sources. The training course leads to qualification for the registry examination in cytology carried out by the American Board of Clinical Pathology. To date approximately 45 persons have been trained in cytology at the State Laboratory of Hygiene and over 30 are believed working in Wisconsin. No other school presently exists in this state.

The Federal support for schools of this nature is of a limited type and the grant may be discontinued at the end of this year or of the coming year. An effort is being made to secure state funds for the continuation of this school. Funds must also be secured from other sources for further support of the trainees. In view of the recruitment difficulties experienced it seems necessary that a stipend program be continued if qualified personnel are to be attracted into this important area. Inquiries regarding our present school should be directed to the school program director, Dr. W. D. Stovall, 437 Henry Mall, Madison 6, Wisconsin. Laboratories in need of cytological help in the near future are urged to make their interests known to the school director at the earliest possible moment.

TABLE 3—*Cytology in the U. S.*

Percentage of Women Over 20 Receiving Cervical Cytology, 1960
(Estimates based on rough approximation only)

State	Population	Estimated Females Over 20*	No. Examined in 1960	No. Path. per 100,000 Population	% of Women Examined
1. Alabama	3.26	1.09	43,000	0.9	4.0
2. California	15.7	5.2	650,000	2.2	12.5
3. Colorado	1.75	0.58	73,000	3.0	13.4
4. Connecticut	2.5	0.8	78,000	2.2	10.0
5. Florida	4.95	1.65	176,000	2.1	11.0
6. Georgia	3.94	1.31	148,000	1.4	11.0
7. Illinois	10.08	3.3	163,000	2.1	5.0
8. Michigan	7.82	2.6	201,000	1.9	8.0
9. Minnesota	3.4	1.1	115,000	2.0	10.0
10. New York	16.78	5.6	280,873	1.8	5.0
11. N. Carolina	4.55	1.5	126,000	4.0	8.4
12. Ohio	9.70	3.2	267,000	1.7	8.0
13. Pennsylvania	11.3	3.8	213,195	2.4	6.0
14. Tennessee	3.56	1.69	242,000	1.7	20.0
15. Wisconsin	3.95	1.3	160,000	2.1	12.0

*In millions.

The State Laboratory of Hygiene also maintains a slide library with many boxes of slides for training and review. These are available on short term loan and include some 3,300 vaginal and cervical smears, 855 smears from the respiratory tract, 490 exudates and many other types of cytological preparations.

This past year the State Laboratory of Hygiene presented a 3-day workshop on cervical cytology under the direction of Dr. S. L. Inhorn, to which interested pathologists and cytologists in the state were invited. This was attended by approximately 11 persons.

The Division of Cancer Control of the State Board of Health provides consultative and educational services in cancer control including films and pamphlets. In addition, assistance to communities or county medical societies on establishing community cytology centers is available through the State Laboratory. The speaker's directory for county medical societies and councilor district meetings published by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin includes speakers willing to talk on topics related to cancer and to cervical cytology. Pamphlets on cervical cytology are also available from the Wisconsin Division of the American Cancer Society as is an excellent film entitled "Time and Two Women."

TABLE 4—*Cytology in the U. S., 1960*

American Cancer Survey

Total pathologists queried	3,534
Per cent replying	83%
Present number of cytotechnicians	1,340
Number extra wanted in next 6 months	310
Total cases done in 1960	5,100,000
Prepared to do in 1961	6,190,000
Estimated per cent total female population over 20 receiving cervical cytology	10%

Discussion. The State of Wisconsin has a good start in the provision of cytology services for its female population over 20 years of age through both public health and private laboratories. As of 1962 approximately 14 to 15 per cent of the eligible women will receive this examination. The urgent point to be emphasized now is the need for the extension of existing services and the development of new community cytology centers. Space, budget, and available personnel are all limiting factors in the future development of facilities. A concerted effort is needed. County medical societies might now consider mechanisms of establishing community services, perhaps in conjunction with adjoining counties, to offer widespread coverage, efficient service, good follow-up, and reasonable cost. Provision must also be made for the provision of this test to the medically indigent. Many private laboratories have indicated a willingness to carry out such examinations for the medically indigent when the physician makes either no charge or a nominal charge for the collection of the specimen. In order to provide for the greatest efficiency, lowest cost, and widest availability to physicians of the area, the establishment of central community cytological centers separate from the hospitals is suggested. The organization and operation of one such community center is the subject of a paper by Dr. Philip Piper describing the experiences in Dane County, and is included in this issue of the *Wisconsin Medical Journal*. The medical department of the State Department of Public Welfare has agreed to the principle that the cervical cytological examination is part of good medical care and can be paid for in a routine physical examination. This must be implemented and approved locally by each county welfare group on the request of the physicians. In this way, this test can probably become available to all individuals on public welfare roles.

The methods of meeting the need for expanded cytology services deserve the attention of organized medicine. One such meeting was held October 25, 1962, at the State Laboratory of Hygiene. Representatives were invited from the Cancer Control Division of the State Board of Health, the State Medical Society, Wisconsin Division of the American Cancer Society, Wisconsin Academy of General Practice, Wisconsin Society of Pathologists, Wisconsin Society of Obstetrics and Gynecology, and Wisconsin Society of Internal Medicine. It is hoped that future discussions within these groups and in the county medical societies will result in plans for expanded services.

A list of laboratories presently doing cytology can be obtained from the State Laboratory of Hygiene.

Summary. The existing cytology services in Wisconsin are reviewed. The elimination of deaths from cervical cancer is possible if this test is carried out yearly on all adult women. This can be accomplished by the expansion and development of cytology facilities, particularly of local cytology centers. The medical profession is faced with an important challenge which can be met by organized effort.

REFERENCES

1. Calabresi, P., Arvold, N. V., and Stovall, W. D.: Cytological screening for uterine cancer through the physician's office, J.A.M.A. 168: (Sept 20) 1958.
2. Horn, D. and Siegel, A.: National survey of cytologic facilities, a special report, CA 11: 97–100 (May–June) 1961.
3. Katz, S.: Two years of cytologic experience in the state laboratory, presented at the meeting of the Association of State and Provincial Public Health Laboratory Directors held in Miami, Florida, October 1962.

CAREER GUIDE IN THE HEALTH FIELD NOW AVAILABLE

The Wisconsin Health Council, Inc. has published with the support of interested groups including the State Medical Society a Career Guide which outlines in detail career opportunities in 26 health vocations. The brochure, which took almost a full year to prepare, is available upon request to the Wisconsin Health Council, Inc., Box 1109, Madison 1, Wisconsin.

Cervical Cytology in Medical Practice Today

By BEN M. PECKHAM, M. D., Madison, Wisconsin

■ SINCE THE demonstration of the value of cytology in detection of cervical cancer by Dr. George Papanicolaou in 1943,[1] this procedure has gained wide acceptance throughout the world. Due to the vision and investigative bent of Dr. William D. Stovall, Wisconsin—through the aegis of the State Laboratory of Hygiene—has been in the forefront of development and utilization of this valuable tool for diagnosis and mass screening. The physicians of Wisconsin have recognized the value of this procedure, judging from the phenomenal increase in the number of patients examined each year through the facilities of the State Laboratory of Hygiene. (See Doctor Evans' data elsewhere in this issue.) To a large degree the increase in utilization between 1956 and 1960 reflects the impact of the Cancer Demonstration Program which is now terminated. However, the fact that laboratories other than the State Laboratory of Hygiene are now responsible for more than 45 per cent of the total cytologic examinations in the state indicates the continued increase in the use of this procedure despite curtailment of this experimental program. The fact that less than 15 per cent of Wisconsin women over age 20 were examined in 1960 indicates that the use of this procedure is still largely diagnostic. It is true that we have within our grasp the tools necessary to eliminate deaths from cancer of the cervix, the most common form of cancer in the female, but it is also true that this goal is not likely to be achieved by present methods.

The purpose of this communication is to review the place of this procedure in diagnosis, examine its true screening potential, and consider avenues of research likely to lead to elimination of squamous cell carcinoma of the cervix as a serious threat to our female population.

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When Is a Smear Diagnostic and When Is It a Screening Procedure? Used in the physician's office upon a patient who has reported voluntarily because of symptoms or because of a desire for a complete evaluation of her health, the examination of cervical cytology is merely another diagnostic tool. While of great value in this connection, its true screening value is very limited. True screening use implies testing of large segments of the population without selection other than as applied to the group as a whole such as limitation as to age. The term screening as used here refers to attempts aimed at uncovering unsuspected disease in a large segment of the population, not only those individuals intelligent or farsighted enough to seek prophylactic care from a physician.

The Place of the Vaginal-Cervical Smear in Diagnosis. The effectiveness of this tool in the diagnosis of cervical lesions has been so thoroughly demonstrated that it is not necessary to review the supporting literature. The physician regularly performing vaginal examinations would find it difficult to practice without this diagnostic aid. We all depend upon it heavily to detect patients with invisible malignancies among those constituting the majority of our clientele, who have no obvious cervical pathology. However, many physicians fail to appreciate some of the limitations of this technique and the importance of simple office biopsy as a correlary procedure.

The false negative. The cervical smear alone should never be depended upon in the presence of a frankly suspicious lesion of the cervix. The overall false negative rate determined by simultaneous cervical smear and biopsy is between 6 per cent[2] and 11 per cent.[8] The fact that false negatives occur with significant frequency is further confirmed where a given population is examined a second time within a period of a year. Under these conditions a significant number

of lesions will be found which were missed on first examination.[3]

The positive smear. Strictly speaking the positive smear cannot be used as proof of malignancy. Positive tissue diagnosis is required for this purpose both from the medicolegal standpoint and, more importantly, for the purpose of selecting appropriate therapy. However, the report of positive cytology is so frequently associated with the subsequent proof of malignancy that the search for a focus of malignancy when the smear is positive must be carried to extremes at times if one is not to miss an occasional unusual malignancy. An example of this is the finding of a positive smear followed by a negative cervical biopsy, surgical cone, and curettage. Under such circumstances, one must consider the possibility of ovarian carcinoma as desquamated cells from these tumors are occasionally found in the vagina.

The negative smear. The negative smear can only be considered reliable for the exclusion of cervical lesions and then only in the absence of a gross lesion. The scraping technique proposed by Ayre[4] has become the preferred technique in the preparation of smears made for the exclusion of cervical malignancy for obviously this technique will increase the number of positive smears by increasing the percentage of cells from the site of most frequent malignant change, the squamo–columnar junction. For the same reason, this procedure will reduce the number of false negative smears. However, this technique decreases the likelihood of detection of endometrial malignancy for these cells are most often found in the pool of secretions in the vaginal fornix. It is presumably for this reason that the State Laboratory of Hygiene furnishes two slides with equipment for both scraping the cervix and dipping material from the vaginal vault and has offered to read both preparations for those desiring both procedures.

Although Calabresi, et al.[5] in reviewing the experience at the State Laboratory of Hygiene in 1958 reported that 25 per cent of the malignancies detected were of endometrial origin, it is widely recognized that the vaginal smear is not a highly reliable method of detecting this disease. In fact, negative smears in the presence of endometrial and ovarian malignancies occur with such regularity that this procedure must be considered of no value in excluding their presence, particularly if symptoms are present. The high percentage of endometrial malignancies detected in this study obviously relates to the fact that many symptomatic patients were included and aspiration smears from both the vaginal fornix and cervix were used exclusively, a procedure which reduced the number of cervical lesions detected and increased the number of endometrial lesions found.

If in the interests of economy it is necessary to curtail the screening services offered by the State Laboratory of Hygiene, it would seem most desirable to reduce the load by dropping the vaginal vault specimen and *not* reducing the number of patients screened by cervical scraping. This would cut the load in half without seriously reducing the effectiveness of the program in the most important area of service, namely the detection of cervical cancer.

The atypical smear. The significance of the presence of "atypical cells" (neither entirely normal, nor frankly suspicious or positive) remains the most controversial aspect of cervical cytology today. The frequency with which such reports are rendered to the physician will depend on the interpretation of the screeners and pathologists in any given laboratory. However, if one excludes the minor degrees of atypia frequently associated with inflammatory conditions, approximately 20 per cent of patients harboring such cells will be found to have some significant abnormality of the cervical epithelium. For this reason tissue examination is highly desirable.

Biopsy and surgical cone. It is in the group with atypical smears that office biopsy has its widest application because it will make unnecessary for the vast majority of this group the hazards and hospital expense of the more extensive surgical cone. When properly done (at least four "quadrant" biopsies from the squamo–columnar junction), negative cervical biopsies make cone unnecessary unless the smear remains repeatedly atypical. Even when the smear is suspicious or frankly positive, biopsy should not be neglected, for coning is highly undesirable when extensive invasive carcinoma (even if covert or hidden) is present in the cervix. Wide surgical incision in these lesions is responsible for occasional distant metastases but, even more important, reduces the

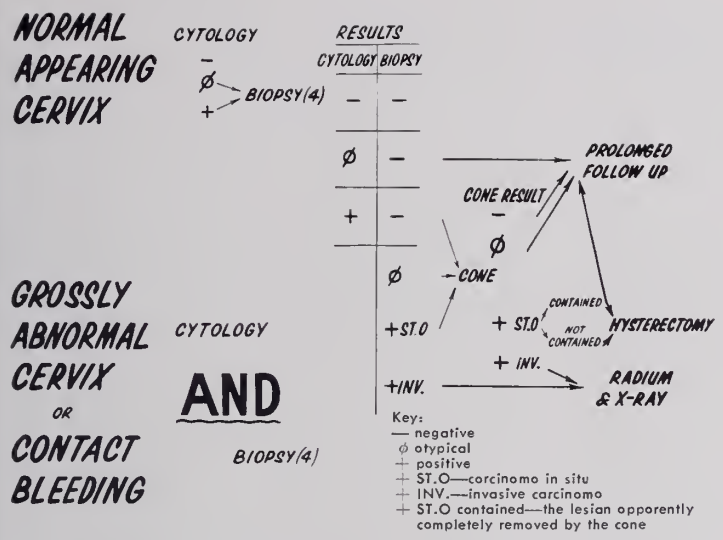

Fig. 1—Flaw sheet showing relationships between cytalagy, cervicol biopsy, ond cone. The schema is entered at the left, the cervix being either normal or grossly abnormal and/ar symptamatic. In the first instance cytalagy suffices, biopsy being indicated as shown by the arraws. In the secand instance, cytalogy ond biopsy shauld be done cancomitantly. The decisian as to cane can only be reached after the results of cytology and biopsy are knawn. Where cane is unnecessary, appropriate treatment is indicated. The results of the cane allaw decision as ta therapy in the remaining instances.

effectiveness of radiotherapy by reducing the size of the vaginal fornices and impairing the fit of the usual vaginal radium applicators. The writer's view of the proper relationship between the complementary diagnostic procedures of cytology, biopsy, and cone is presented in the form of a flow sheet in Figure 1.

The Screening Potential of Cytology. The 14-county program during which 70 per cent of the women over 20 years of age were screened in a four-year period demonstrates conclusively what could be done if the same level of physician and patient participation could be obtained in all 72 counties of the state. It does indicate, however, the practical impossibility of achieving, by these means, the ideal of examining 100 per cent of the women over age 20 in the state at yearly intervals. Not only would this place an almost impossible burden on physicians and their office facilities and necessitate vast laboratory and technical assistance, but also it seems unlikely that the necessary 100 per cent patient acceptance could be obtained. If we are willing to settle temporarily for less than our goal of complete elimination of invasive carcinoma of the cervix, and under present conditions we must, then it follows that the proper course of action is to press for expansion of community facilities and continue efforts to increase the interest of patients and physicians in prophylactic cancer examinations in general and cervical cytology in particular. Various approaches to the problem are discussed by Dr. Philip Piper elsewhere in this issue.

The ultimate goal can be reached if present procedures can be altered in such a way as to: (1) increase patient acceptance, (2) relieve the physician of the time-consuming task of pure screening, and (3) dispense with the necessity of human inspection of every or even the majority of cytologic preparations.

Current and Future Research. Recently Davis[3,6] has reported and is testing a new technique which may go far toward providing the first two of the three prerequisites noted above. A simple plastic device has been designed which contains a fluid medium capable of preserving cells in satisfactory condition for later examination. The device, which can be mailed or distributed, allows the individual to collect a sample of exfoliated cells by intravaginal injection and retrieval of the fluid medium. The sample is then returned to the laboratory for preparation of cell spreads for interpretation. If abnormal cells are found, the result is returned to the individual with instructions to see her physician for further examination.

Obviously the accuracy of this technique will not equal that of the cervical scraping, but it should be capable of increasing patient acceptance to the point where yearly screening will become possible without inundating the physician with normal patients. Done at yearly intervals false negatives would be reduced to an insignificant figure in a few years because of the prolonged period of incipiency (Stage O or carcinoma in situ) that most of these lesions display.

There remains, however, the major bottle neck of laborious screening which cannot

be reduced much beyond 10 minutes per slide by present methods. At 1.3 million preparations per year this comes to more than 200,000 hours of screening time per year. Until the time necessary for the review of specimens can be reduced by a large factor there seems little hope of really massive screening programs. In this age of automation it would seem logical to assume that the problems of automated microscopic screening should not be overwhelming. Extensive research along these lines has led to the development of complex optical-electronic instruments capable of automatically scanning Papanicolaou smears. These devices, called cytoanalyzers,[7] measure the optical density and area of every cell in such smears, classifies each into one of five or six size-density classes, thus permitting detection of cells whose nuclei exceed the limits possessed by normal cells. Unfortunately such factors as the evenness of distribution of cells and the amount of extraneous material have proved an important limiting factor in the operation of such equipment. To date these devices must remain research tools until such time as these technical problems can be overcome or some entirely new approach to the problem discovered.

Conclusion. While there can be no doubt that cervical cytology has made a tremendous contribution to medicine in the detection and management of cervical lesions, exploitation of its full potential must await improved techniques and wider patient acceptance. Until then carcinoma of the cervix will continue to be a major cause of disability and death among Wisconsin women.

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REFERENCES

1. Papanicolaou, G. N. and Traut, H. F.: Diagnosis of uterine cancer by the vaginal smear, New York, The Commonwealth Fund, 1943.
2. Kaminetzky, H. A.: Clinical aspects of exfoliative cytology, Illinois M. J. 113:117, 1958.
3. Davis, H. J.: Irrigation smear, a cytologic method for mass population screening by mail, Am. J. Obst. & Gynec. 84:1017, 1962.
4. Ayre, J. E.: Simple office test for uterine cancer diagnosis, Canad. Med. Assoc. J. 51:17, 1944.
5. Calabresi, P., Arvold, N. V., and Stovall, W. D.; Cytological screening for uterine cancer through physicians' offices, J.A.M.A. 168:243, 1958.
6. Davis, H. J.: Irrigation smear; accuracy in detection of cervical cancer, Acta Cytol. 6:459, 1962.
7. Tolles, W. E.: Methods of automatic quantitation of microautoradiographs, Lab. Invest. 8:99, 1959.
8. Greene, R. R.: Personal communication.

EXPERIENCE WITH CYTOLOGY IN DIAGNOSIS OF UTERINE CARCINOMA IN A PRIVATE HOSPITAL

In the March, 1956, issue of *The American Journal of Clinical Pathology,* Doctors Edward A. Birge and David J. Carlson from the laboratories of the Milwaukee Hospital, Milwaukee, Wisconsin, reported this experience. During the five years from 1950 through 1954, cytologic smears were made a routine office procedure by the staff of Milwaukee Hospital. During that time, smears from 7,577 women were examined and 585 (approximately 8%) had smears which showed some cytologic abnormality. These smears were examined in the hospital laboratory. Originally the smears were made from aspirates of the vaginal secretions, but later it was found that the cervical scrapings produced more satisfactory smears.

Of the 585 patients showing cytologic abnormality, 82 were found to have cytologically proved carcinoma. The carcinoma was usually early and asymptomatic. False positives were encountered, since the Papanicolaou smear is a screening procedure rather than an absolute diagnostic method. Five false negative smears were also obtained and four of these were attributed to lack of experience on the part of the examiner. The other false negative was reported in a patient with ulcerating carcinoma of the cervix.

It was the experience of Doctors Birge and Carlson that the Papanicolaou smear was valueless for diagnosis of endometrial carcinoma. However, endometrial curettings obtained with a Novak curet, as a routine office procedure among 1,685 patients, disclosed carcinoma of the endometrium in 12 patients without symptoms and in 7 with symptoms.

The authors concluded that cytology is a useful diagnostic tool provided the pathologist is willing to spend the time necessary for its proper utilization, and that cytologic methods will yield the best results when applied routinely to all patients presenting themselves for pelvic examination. Abnormal cytologic smears should always be confirmed by histologic study of the cervix. They stated that the smear is most useful for the diagnosis of early asymptomatic carcinoma of the cervix. In frank clinical carcinoma of the cervix, tissue should be taken for biopsy instead of relying on the smear. The Papanicolaou smear is preferred to single or multiple biopsies for the diagnosis of early asymptomatic carcinoma.

Trends in Three Cancer Sites

By A. L. VAN DUSER, M. D., M. P. H.

Modison, Wisconsin

■ PUBLIC HEALTH agency efforts to bring about improved control of cancer are primarily directed at cancer located in sites accessible for early diagnosis, and lay and professional practices that contribute to the early detection and prevention of cancer. The consideration of what effect, if any, control endeavors are having upon mortality and morbidity trends of certain cancers is of interest.

Both cancer deaths and cases are reportable to the State Board of Health. Mortality reporting is quite complete and averages in excess of 6,000 deaths yearly. Morbidity reporting is incomplete, numbering 6,676 cases in 1960, but for reasons that need not be discussed here, the cases appear to be representative of the total incidence. Although medical deficiencies and inaccuracies exist in death reports and even more in case reports, these sources of information are reliable enough to indicate effects or trends resulting from cancer control efforts.

For this purpose three kinds of cancer information are tabulated for recent periods for the sites of the uterus, breast, and lung. Death rates, Table 1, indirectly indicate changes in the percentage of cancer being cured. The average age of death from cancer, Table 2, reflects progress in case management and therapy through changes in the duration of life of those patients who are essentially incurable. The percentage of localized cancer found at the time of diagnosis, Table 3, is a measurement of early case finding efforts.

The data pertaining to uterine cancer show that considerable progress is being made against this cancer. Cytology services became available to Wisconsin physicians in 1947; the yearly number of cytologic tests now being done in public and private laboratories is about 160,000. The cytologic test, and the added stimulus that it has given to women and the medical profession to seek uterine cancer and obtain or provide good pelvic care on a mass basis, has undoubtedly been the major cause of the improving picture. The data support the impression of the medical profession that the ready availability of cytology services and the wide application of this test in case finding and pelvic care programs can reduce uterine cancer mortality to a fraction of its present level.

The small increase in the average age of death from breast cancer suggests that these patients are living only about a year longer

TABLE 1—*Crude Cancer Death Rates, Per 100,000 Population, Selected Sites, Wisconsin, 1950–1961*

Period	Uterus, Excluding Cervix	Cervix	Breast	Lung*
1960–61	3.00	3.68	14.29	15.61
1958–59	3.14	3.79	14.68	14.30
1956–57	3.00	4.46	15.10	14.88
1954–55	3.29	5.11	14.74	12.72
1952–53	3.29	5.07	15.74	11.44
1950–51	3.60	4.91	14.68	10.56

*Includes Trachea, Bronchus and Lung.

TABLE 2—*Average Age, in Years, Cancer Deaths, Selected Sites, Wisconsin, 1950–1961*

Period	Uterus, Excluding Cervix	Cervix	Breast	Lung*
1960–61	68.84	59.27	62.85	64.75
1958–59	68.26	60.55	62.95	64.05
1956–57	65.94	58.36	63.70	64.00
1954–55	64.88	58.93	62.80	63.60
1952–53	66.93	58.58	60.90	63.00
1950–51	64.10	56.49	61.55	62.75

*Includes Trachea, Bronchus and Lung.

TABLE 3—*Per Cent Cancer Cases Reported as Localized, Selected Sites, Wisconsin, 1950–1960*

Period	Uterus, Excluding Cervix	Cervix	Breast	Lung*
1960	75.76	74.07	40.77	17.22
1958–59	77.39	74.14	43.81	17.62
1956–57	68.60	68.47	45.99	17.47
1954–55	65.27	59.77	42.33	15.95
1952–53	61.30	58.35	44.12	23.29**
1950–51	54.37	46.53	37.85	15.14

*Includes Trachea, Bronchus and Lung.
**Obviously an error—due to tabulating or coding error during 1952

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as the result of improving management and therapy. Recent efforts to find a larger percentage of breast cancer in a localized curable stage, and to reduce the death rate, do not appear to have been successful. There exists a viewpoint that the majority of breast cancers might have early significant spread before the primary lesion reaches detectable size. If this is true, the hope that improved breast cancer cure rates can be achieved through early (localized) case finding rests upon primarily erroneous assumptions. However, the percentage of lesions assumed to be localized has not increased and this in itself suggests the probability that a part of the cure rate problem is a failure of the public and the profession to bring about the examination of an adequate number of breasts to permit finding lesions when they are curable. The writer knows of no sizable population where the practice of breast self-examination is being adequately performed. Cancer of the breast is causing about 1 in 5 of all cancer deaths in women, and mortality rates from this disease show no observable trend. All possible approaches to improve the control of this cancer merit full implementation.

Except that lung cancer patients appear to be living a year or more longer, the data on cancer of this site are very unfavorable, showing a substantial increase in the number of deaths and in the death rates. While the biochemical process by which the normal cell is converted to a malignant cell as the result of intensive cigarette smoking is unknown, numerous reports have been accepted by authorities as reliable fact that cigarette smoking is the major cause for the increase in lung cancer. In beginning educational programs, the prevailing philosophy has been that the confirmed cigarette smoker can be written off to the increased risk of lung cancer and that efforts should be directed at the prevention of the cigarette habit in youth. Unfortunately, the pattern of smoking in youth is pretty much determined by the smoking habit and attitudes of the parents, and youth have indicated that they are not ready to accept cigarette smoking as a serious health hazard until their parents and their source of reliable medical information —the medical profession—set the appropriate leadership. It is of paramount importance that the medical profession and public health agencies take an aggressive position on cigarette smoking if lung cancer prevention and better control is to be achieved. Passive support, wait and see attitudes, and anemic anti-smoking programs cannot solve this health problem. In view of the established evidence of the carcinogenicity of the cigarette smoking habit and its resultant ever-mounting toll of lung disease and death, the undue tolerance and the failure of the providers and promoters of good health to mount a substantive course of corrective action is most unrealistic.

OPTIMUM SPACING OF REPEAT FOLLOW-UP PAPANICOLAOU SMEARS

In the Sept. 20, 1958, issue of *The Journal of the American Medical Association*, Doctors David J. Carlson and Edward A. Birge of Milwaukee reported on the results of 15,389 cytological examinations for carcinoma of the cervix uteri. They analyzed these results for the purpose of deciding how frequently such tests should be repeated. Approximately 65% of the examinations were repetitions on the same women, since the group represented a small, relatively constant segment of the population closely watched over a period of years. In four cases there was a conflict of findings, but with that exception the authors found only a single patient who, having had initially normal smears, exhibited cytological abnormalities at subsequent examinations. The data showed that periodic cytological examination yields diminishing returns and that new cases generally represent the introduction of new members into the group. The evidence led to the conclusion that lengthening the interval between cytological examinations to two years will not appreciably increase the risk to the patient if pelvic examinations are done at the same time.

Their conclusions were based on the statistical follow-up for three years and on the authors' impressions covering a period of approximately seven years. They felt that if these observations could be substantiated, the application of the cytological examination will become greatly simplified, since it need not be repeated as often as has been recommended in the past.

CLINICOPATHOLOGIC CONFERENCE

P
C

Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: THOMAS R. SIMON, M. D.
Milwaukee, Wisconsin

Case Presentation.* This patient was a 79-year-old white female who entered the hospital on July 4, 1962, with complaints of vaginal bleeding and lower abdominal pain of two weeks duration. Since 1955, she had been known to have mild hypertension and diabetes, which was controlled with 45 units NPH insulin daily. She gave a history of having been pregnant four times and of having four uncomplicated deliveries. Menarche was at age 16. Periods were regular at 28-day intervals, lasting three to four days. Menopause was at age 56. In 1953 when the patient was 69 years old, endometrial curettage, done because of vaginal bleeding, led to a diagnosis of endometrial carcinoma. Because the patient was considered a poor surgical risk, treatment with irradiation only was chosen. It consisted of 3,000 R. by Heyman capsules and 12,000 R. by four external ports. Until the onset of the present symptoms, there had been no additional vaginal bleeding.

Two weeks prior to the present admission, she noted vaginal spotting, just enough to soil underclothes, and pain and a sensation of fullness and swelling in the suprapubic region. She denied urinary or bowel symptoms. Review of the systems was otherwise negative, except for moderate dyspnea on exertion.

On admission, she weighed 154 lb. (70 kg.) and was 5 ft. 1½ in. (157 cm.) tall. Blood pressure was 160/60. Other pertinent physical findings were limited to the abdomen, which was soft and flat, with normal intestinal sounds. A firm, tender suprapubic mass, measuring 6 by 8 cm. was palpated by one examiner; however, its presence was questioned by another. The uterine fundus was retroverted, measured 5 by 7 cm., and was globular and fixed in the cul de sac. From a round, normal-sized cervix protruded a small red mass. There was an exocervical erosion. The left parametrium was hard and thickened out to the lateral pelvic wall. The right parametrium was similar, but the induration did not reach the pelvic wall. Both sides were moderately tender. Proctoscopic examination was negative to six inches, where external obstruction prevented further passage of the scope. No intrinsic intestinal lesion was noted. Vaginal-cervical smears and biopsies of cervix, endocervical canal, and endometrial cavity were taken on admission.

Laboratory studies revealed a hemoglobin level of 13 gm. per 100 ml., hematocrit reading of 41%, white blood cell count of 10,700 per cu. mm. with a differential count of 25 stab forms, 45 segmented neutrophils, 25 lymphocytes, and 5 monocytes. Urinalysis was negative for sugar and albumin. There were 2 to 3 red blood cells and 3 to 6 white blood cells per high-power field in urinary sediment. Urine specific gravity was 1.015. Fasting blood sugar was 127 mg. and plasma urea nitrogen 16 mg. per 100 ml. Serum chlorides were 105, carbon dioxide capacity 26, sodium 138, and potassium 4.2 mEq./L.; total protein was 6.8 gm. per 100 ml.

A roentgenogram of the chest showed moderate cardiac enlargement. Intravenous and retrograde pyelograms showed hydronephrosis on the right side. Barium enema was negative.

Electrocardiographic studies showed evidence of anterior myocardial infarction, age undetermined.

Discussion. *Dr. F. Jackson Stoddard:* In discussing this case, a number of points are immediately apparent. This woman had a late menopause, having menstruated until age 56; she was diabetic, moderately obese, and hypertensive, or at least had an elevated systolic blood pressure. All of these characteristics are said to occur much more commonly in patients with endometrial carci-

* From Milwaukee County General Hospital, Milwaukee.

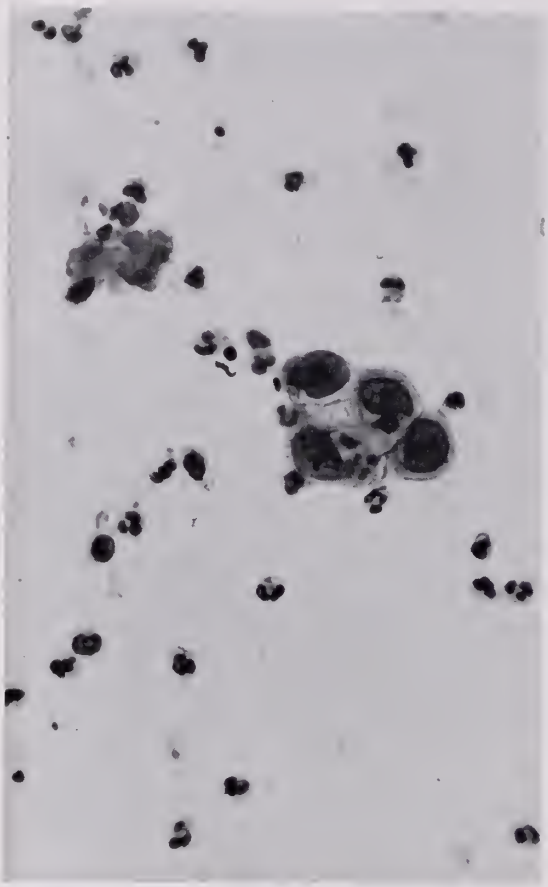

Fig. 1—A cluster of abnormal cells on vaginal-cervical smear. The enlarged hyperchromatic nuclei and the tight clustering suggest adenocarcinoma.

noma than they do in the general female population of a comparable age group.

The fact that she was considered a poor operative risk 10 years ago indicates a change in concept of what constitutes a poor surgical risk. It is generally realized that the primary therapy for endometrial carcinoma is surgery and that irradiation is merely an adjunct. Now very few, if any, physicians would evaluate this patient as too poor a surgical risk to stand an abdominal hysterectomy. It is evident that she had incomplete therapy for her initial cancer.

Now we are presented with a 79-year-old woman who had had bloody vaginal discharge and discomfort in the suprapubic area for several weeks. She had a globular mass in the cul de sac which was interpreted to be a uterus, as well as a questionable mass anteriorly and suprapubically. Additional significant findings on speculum examination showed a small erosion of the cervix and a reddish mass protruding from the cervical canal. Without knowing what the smears and biopsies of the mass showed, a number of possibilities come to mind. The cervical lesions could be an erosion with a polyp—either endometrial or cervical, carcinoma of the cervix metastasis from a carcinoma elsewhere in the body, or possibly recurrence of the endometrial carcinoma. Specific granuloma is a remote possibility.

The mass anterior to the uterus could be due to pyometria or hematometria, following cervical stenosis resulting from radiation, an ovarian carcinoma or an ovarian cyst, a Fallopian tube lesion either malignant or inflammatory, a full bladder or a prolapsed adherent segment of large or small intestine. It should also be considered that the lesions might all be portions of a granulosa cell or a theca cell tumor which has been present for a period of years but which has been inhibited in its growth by the irradiation therapy. The original endometrial carcinoma might have arisen coincidentally with the granulosa cell tumor. It is well known that between 15 and 25 per cent of granulosa cell tumors are associated with endometrial carcinoma.

The laboratory data, other than supporting the diagnosis of diabetes, do not help in the gynecologic diagnosis.

X-ray studies indicate a hydronephrosis on the right side which might be related to ureteral compression as a result of the indurated left and right parametrial areas. This induration could be either inflammatory or neoplastic in origin. After learning what the pathologist found on the smears and biopsies, we can probably narrow down the possibilities. Doctor Simon, would you discuss the smear and biopsy findings?

Dr. Thomas R. Simon: The smears (Fig. 1) showed numerous small clusters of abnormal cells having large, hyperchromatic nuclei and scanty cytoplasm. The presence of prominent nucleoli and the tendency toward arrangement in small, rounded clusters led to a cytologic diagnosis of adenocarcinoma. Biopsy specimens taken from the mass protruding through the endocervix and from the endometrial cavity showed, in addition to adenocarcinoma, a sarcomatous stroma in which specific types of mesenchymal elements were not identified (Fig. 2). The diagnosis was malignant mesodermal mixed tumor of Müllerian duct origin.

Doctor Stoddard: It would not appear necessary in this case to perform a dilatation and curettage, since the biopsy of the cervical lesion showed very definite evidence of malignancy. Also, dilatation and curettage would carry the risk of perforation of the uterus. Furthermore, it would be necessary to perform a laparotomy to determine the nature of the suprapubic mass. It would appear that the only possible treatment in this case is radical surgery, the extent to be determined by the nature of the lesion at the time of exploration. It would be my feeling that the patient should have catheters inserted into the ureters prior to surgery to aid the operator in avoiding them at the time of the exploration. Certainly, this patient at the age of 79 is not a candidate for such a procedure as an exenteration, and probably only removal of the uterus, tubes and ovaries, and as much parametrium as possible, is indicated. Even so, the prognosis of a mixed mesodermal tumor of Müllerian duct origin is extremely poor with any form of therapy. However, I feel that she does deserve at least exploration and extirpation of as much of the tumor as possible.

Concerning the etiology of this particular tumor, I think that it is interesting to speculate as to whether the irradiation that this patient had 10 years ago may be related to the development of the new tumor. It has been claimed that individuals having had radiation castration are particularly liable to develop endometrial carcinoma. This has been buffeted about for a long time without proof or refutation. It seems to me that at the present time the consensus among gynecologists is that the incidence of malignancy following irradiation is no higher than would be expected in the population at large. I would like to ask Doctor Grueninger for his opinion on this point, also how he feels about radiation therapy alone for endometrial carcinoma, and finally, whether he would recommend further radiation therapy for this patient now.

Dr. Anthony Grueninger: I do think that there is a definite possibility that in this case irradiation contributed to the later development of the mixed mesodermal tumor. There seems to be an inordinately high percentage of cases of this type of tumor having a history of previous irradiation. There are, of course, many instances in which this tumor has arisen with no previous irradiation. We do not believe that the doses of irradiation which formerly were given for sterilization contributed appreciably to the development of endometrial carcinoma. Most of those patients were irradiated because of heavy menses, and one might speculate that they had hyperplasia which, in some instances, may have been premalignant.

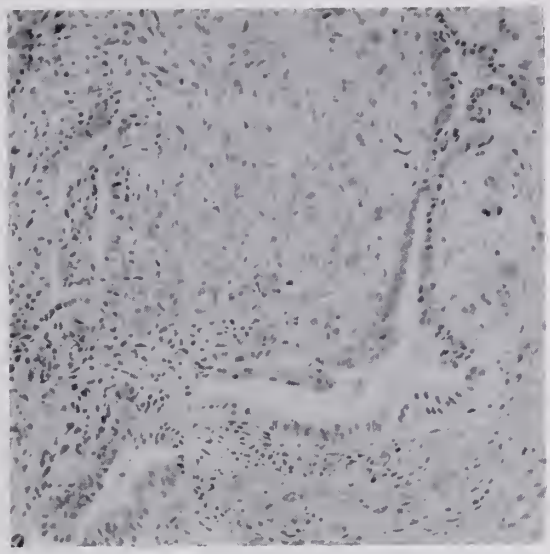

Fig. 2—Biopsy of mass protruding through cervical os. There are imperfect glandular structures lying in a sarcamatous strama.

Preoperative irradiation of carcinoma of the endometrium reaches its highest estate when there is extension of the disease outside of the uterus; and, since in operated cases the incidence of metastases to local lymph nodes has been as high as 15 per cent, most radiotherapists throughout the world favor preoperative irradiation in the hope of destroying metastatic tumor in lymph nodes. In addition, we know that it is possible to cut down on the incidence of vaginal recurrence from over 5 per cent in untreated cases to about ½ of 1 per cent in the irradiated cases. In light of reported cure rates as high as 88 per cent using combined radiation and surgery, I certainly do not think that irradiation alone is the treatment of choice.

Summarizing this patient's previous therapy, it seems that she had a dose of approximately 7,000 R. to the midline in the region of the uterus. I would hesitate to irradiate further an elderly woman who, by this time, has fibrotic changes and impaired vascularity. In addition, even if this patient had

Fig. 3—The partially dissected uterus showing an irregular polypoid mass arising from endometrial wall and protruding through the cervical canal.

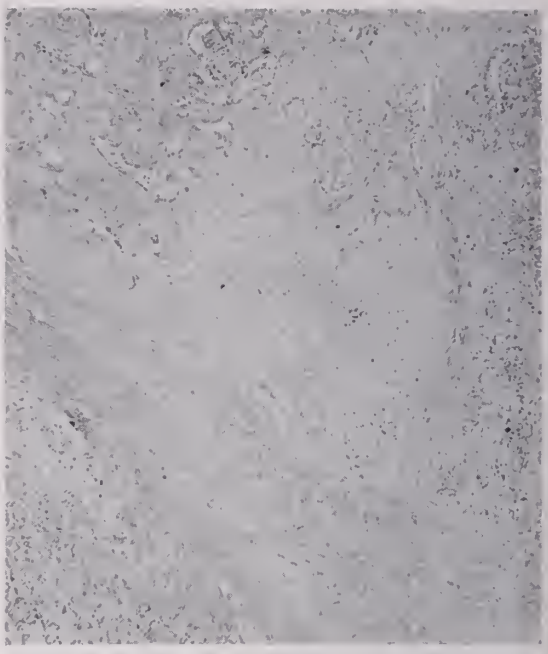

Fig. 4—A field showing a combination of poorly differentiated adenocarcinoma and sarcoma, one area of which is cartilagenous.

not had previous irradiation, I would be unenthusiastic, because mixed mesodermal tumors are notoriously radio-insensitive. It is occasionally possible to get a transient regression in the size of the uterus, but these patients often die of widespread metastases before the irradiation causes any appreciable change. These tumors are not curable by irradiation.

Doctor Simon: At operation, marked evidence of radiation reaction was noted over the anterior abdominal wall. Sigmoid colon was adherent to the posterior uterine surface. The intestinal wall and peritoneum were markedly thickened. A 7 cm. ovarian cystic mass on the right side was noted adherent both anteriorly and posteriorly. The uterus, both tubes, both ovaries, and parametrial tissues on both sides were removed. Figure 3 shows the opened uterus. Arising from the endometrial wall and protruding through the endocervical canal was a broad-based, polypoid mass, which was soft and partially hemorrhagic. In addition, at the fundus, there was a rounded localized intramural tumor mass having gross and microscopic features of leiomyoma. Sections of the polypoid tumor showed adenocarcinoma, mostly poorly differentiated, in association with a sarcomatous stroma. Careful search for immature striated muscle cells was unsuccessful; however, islands of immature cartilage were identified (Fig. 4). The adenocarcinomatous element of the tumor extended through the entire thickness of the myometrium and was noted in small metastatic foci in the right ovary, the bulk of which was occupied by a benign serous cystadenoma.

The immediate postoperative course was complicated by respiratory difficulty, with x-ray evidence of atelectasis. Elastic stockings were applied, and the patient's condition improved. After a few days the wound was well healed. The patient was maintained on insulin, digitalis leaf, and diuretics. On the fourteenth postoperative day, the patient complained of lower abdominal pain, severe enough to keep her in bed. An electrocardiogram showed changes similar to those noted before operation. On the following day, superficial thrombophlebitis of the left thigh was noted. This responded favorably to

treatment consisting of rest, hot compresses, and elastic bandages. On the twenty-second postoperative day, arrangements were made for the patient's discharge. However, late that afternoon, she complained of shortness of breath, palpitation, and malaise. Blood pressure was 164/70; pulse rate was 96 per minute. An electrocardiogram showed only changes similar to those noted on previous recordings. The patient continued to complain of weakness and malaise and a sense of distress. Episodes of hypotension were treated with vasopressor drugs. However, she failed to respond, and succumbed on the twenty-sixth postoperative day.

Doctor Stoddard: As an explanation for these terminal events, I would consider pulmonary embolism as most likely. Additional recent myocardial damage, which is a possible explanation, gets no support from the electrocardiographic findings.

Doctor Simon: At autopsy, there was thrombophlebitis of the right iliac vein and of the inferior vena cava with bilateral massive pulmonary emboli. Also found was a healed myocardial infarction involving the anterior septal wall with no evidence of recent damage. Microscopic foci of residual adenocarcinoma were found in the connective tissues surrounding the right ureter and involving the serosa of the rectum. There was mild hydroureter and hydronephrosis on the right side, and microscopically the kidneys showed acute glomerulonephritis.

Doctor Stoddard: Was a more aggressive attempt to prevent pulmonary emboli in this patient considered? I can, of course, understand hesitancy to undertake such an operation as vena caval ligation in a patient such as this, but I would like to know what the thinking was.

Dr. Rolland Patillo: From the evidence we had, we felt that the thrombophlebitis was in superficial veins and that this had responded well to conservative treatment. Even in the last few days when we suspected that the patient was having pulmonary emboli, the evidence was not absolute; and, therefore, we did not feel justified in attempting caval ligation.

Doctor Stoddard: Would it be wise to consider the more frequent use of prophylactic anticoagulant therapy against such a situation as this? I know that Doctor Urdan has for many years used anticoagulants in much of his gynecological surgery; and, although he has seen a few more hematomas than the rest of us, he has had impressive results in preventing pulmonary emboli. Such prophylaxis might be even more important in the older population that we deal with in this hospital.

I would like to ask Doctor Simon two questions. First, what is the value of cytology in the detection of malignant mesodermal mixed tumors? Second, what is the outlook for patients with this tumor?

Doctor Simon: The place of cytology in the detection of mixed mesodermal tumors is not a very practical one, since these patients present with signs and symptoms which, by themselves, would demand immediate investigation. In a very high percentage of the cases, it is possible to make a cytologic diagnosis of malignant tumor, and the malignant cells noted are usually those of adenocarcinoma. In rare instances, specific malignant mesenchymal elements, such as immature striated muscle cells, have been identified in the smear, so that a specific cytologic diagnosis could be made.

In answer to your second question, certainly it is rare that a patient with malignant mesodermal mixed tumor is cured. From the literature, it appears that results have been improved somewhat within recent years by early aggressive surgical attack. In those patients in whom treatment is unsuccessful, death is usually associated with widespread metastases which may present as adenocarcinoma, sarcoma, or combinations of both elements.

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PENNSYLVANIA MEDICAL SOCIETY ACTS ON CIGARETTE SMOKING

The House of Delegates of the Pennsylvania Medical Society at its Annual Meeting held in October 1962 adopted the following resolution:

"WHEREAS, The preponderance of the evidence indicates that cigarette smoking is implicated in the genesis of lung cancer and probably other diseases; and

"WHEREAS, The Pennsylvania Medical Society is concerned in all matters relating to the public health; therefore be it

"RESOLVED, That the Pennsylvania Medical Society go on record as advocating the voluntary giving up of cigarette smoking by those already habituated; and be it further

"RESOLVED, That the Pennsylvania Medical Society through an appropriate committee or commission initiate and maintain an educational program designed to influence young people not to start the habit of smoking cigarettes."

ROYAL COLLEGE OF PHYSICIANS REPORTS ON SMOKING

After three years of intensive study, the Royal College of Physicians of London reported to the medical profession and to the public the most critical and comprehensive analysis that has ever been made of the effects of tobacco smoking upon health. This report has focused attention upon this health hazard and has stimulated action not only in England but also in many other countries. Its major conclusions are:

. . . The only benefits of smoking are psychological and social; smoking may help avoid obesity but does not prevent neurosis.

. . . Cigarette smoking is a cause of lung cancer and bronchitis; may contribute to development of coronary heart disease and some other diseases, and delays healing of stomach ulcers.

. . . A study of British doctors shows that for men age 35 the chances of dying in the next 10 years are: 1 in 23 for heavy cigarette smokers and 1 in 90 for non-smokers.—Abstract of MEDICAL BULLETIN ON TOBACCO from *Smoking and Health*, Summary and Report of the Royal College of Physicians of London on Smoking in Relation to Cancer of the Lung and Other Diseases, Pitman Pub. Corp., New York, N. Y., 1962.

AN INDUSTRY SUPPLIED THE "MUSCLE"

The age we live in is rooted in technology. Machines are everywhere and have been devised to do just about everything. These machines and apparatus, and the *expertise* necessary to manage them, were available when antimicrobial agents appeared. Experts in the processes of fermentation readily converted their methods and apparatus to the production of penicillin; pill-producing machines could be devised for turning out sulfonamides or isoniazid in large quantities; quarters used for the production of antipneumococcic serum from thousands of rabbits served well for animals used to test the efficacy of antibiotics. Behind these elaborate facilities were the resources of the pharmaceutical corporations. The industrial capitalism that arose in the 18th and 19th centuries in Europe and America supplied the "muscle" in the war on infections, the money needed to run the machines and to hire the workers. We cannot say that no other way would have been possible; we can say that this method was tremendously effective.—HARRY F. DOWLING, M.D., in *Archives of Internal Medicine*, November 1962.

POLICY STATEMENT ON MAMMOGRAPHY BY AMERICAN CANCER SOCIETY

At its meeting on Jan. 18, 1963, the Board of Directors of the American Cancer Society approved the following policy statement submitted by the Medical and Scientific Committee regarding the use of mammography as a screening procedure.

"The diagnosis of cancer of the breast is a very difficult procedure that requires the services of skilled physicians. When x-ray examinations are used alone as a screening procedure, these physicians, other than the radiologist, are eliminated and the chances of the detection of a cancer, if present, become entirely dependent on the efficacy of mammography.

"Mass screening becomes a practical procedure when most of the asymptomatic cases can be detected; when most positive cases are not missed, and; when only a few false positive cases occur. Although there are several experimental programs underway to determine the accuracy of mammography, they are yet incomplete. When the above criteria for mass screening can be fulfilled, the use of mammography as a screening procedure alone can be recommended.

"Progress is being carefully watched and as soon as it is felt that mammography as a general screening procedure is practical you (divisions of the ACS) will be so notified."

SPECIAL TO THE JOURNAL

Wisconsin Physicians and Cigarette Smoking

By R. J. SAMP, M. D.
Madison, Wisconsin

■ THE PUBLIC, especially the younger age groups, has the impression that most doctors are heavy, inveterate smokers who are unconcerned with the smoking-disease relationship. These opinions are prevalent even though they do *not* agree with a survey of Wisconsin physicians on their smoking habits.

On a speaking tour of 187 state high school assemblies for the Wisconsin Cancer Society this writer found that the most frequent question and challenge from the students was: "If smoking cigarettes is bad, why do so many doctors smoke?" Many students commented on doctors being chronic smokers who minimized the dangers of cigarette smoking. This survey sought to determine how the medical profession felt about cigarette smoking and how the doctors have responded to the reported dangers.

The survey was conducted through the county medical society secretaries who polled their members at regular county medical society meetings. There were 652 physicians polled in this manner. Represented in this sample were 39 counties with a physician population of over 1,600.

The year 1955 was selected because of the abundance and culmination of studies and research reports on the dangers of cigarette smoking published by that time.

The questions asked and the tabulations follow:

How many cigarette smokers have quit since 1955?	84
How many cigarette smokers have cut down considerably since 1955?	34
How many cigarette smokers have continued to smoke since 1955?	246
How many new cigarette smokers since 1955?	5
Other categories: nonsmokers, occasional smokers, pipe or cigar smokers, or smokers who had quit *prior to* 1955	322

The group of 84 physicians who have quit smoking cigarettes since 1955 is very important. Out of the total survey of 330 former cigarette smokers, they represent 25.4 per cent.

Thirty-four doctors cut down considerably on their cigarette smoking. This is more than 10 per cent of the entire group smoking cigarettes prior to 1955. They make up over 13 per cent of the remaining cigarette users.

Although there was no direct question on the point, several reports mentioned a switch or cut down of cigarette smoking in favor of pipe smoking.

No attempt was made at a further breakdown of the remaining physicians who *never* smoked, cigar and pipe users etc. Significantly, however, when this group is added to the "quit smoking cigarettes" group, it shows over 60 per cent of our physicians who *cannot* be judged as chronic, inveterate, addicted, or bad-example-to-youth smokers. Many physicians *do* practice what they should preach! Admittedly the survey is incomplete and rough in form, but there are some interesting trends and encouraging results.

Perhaps the whole idea seems incidental or unimportant to some doctors and not worth the time and effort. May I remind these skeptics that the public health mortality predictions of the National Cancer Institute are that one million lung cancer deaths will occur among the present students, grades 1 to 12, *unless* their smoking habits are changed drastically. Anything to curb or break a habit, especially if the anything is what the students give as a reason they do smoke, should be followed up.

This report does not prove one way or the other the cigarette–disease relationship. The recent report by the Royal College of Physicians of England[1] does this scientifically and convincingly. This survey uncovers the interesting fact that many Wisconsin physicians are concerned enough about cigarette smoking to quit or cut down the number smoked.

Several studies of high school students[2] have shown that young people imitate their elders, especially those whom they respect such as parents, teachers, heroes, leaders, coaches, and doctors. A definite, good example is helpful and in the case of physicians a positive stand against cigarette smoking would undoubtedly influence more young people.

Already the results of this survey have been used before young audiences to show that doctors are serious about the smoking problem. The survey results played a small but helpful part in persuading junior medical students at the University of Wisconsin to sign a pledge to either discontinue the habitual use of cigarettes or not to begin smoking . . . 75 per cent pledged.

Young people can be told that physicians are doing something very constructive about the cigarette smoking dangers. Survey takers are warned that time and patience are needed if answers from doctors are desired. The medical profession generally should be alerted to the fact that they are on display as examples, good and bad, and that the medical profession's influence is very important.

Doctor Samp is Assistant Professor in Surgery, Cancer Research Hospital, University of Wisconsin Medical Center, and Medical Director of the Wisconsin Division of the American Cancer Society.

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REFERENCES

1. Royal College of Physicians' Committee on Smoking: Report; Smoking and Health, Pitman Publishing Corp., New York, 1962.
2. Horn, D.: Cancer facts cut teenage smoking, Sr. Scholastic 76:6–7 (April) 1960.

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

Some Comments on the Pathogenesis of Agranulocytosis

By ANTHONY V. PISCIOTTA, M. D., Milwaukee, Wisconsin

■ UNEXPECTED toxic reactions on the blood and bone marrow, induced by drugs, are well known. The first of these to be recognized was agranulocytosis due to amidopyrine.[1] The clinical relationships in this disorder were sufficiently clear cut to provide important clues regarding its pathogenesis. For example, only a few milligrams of the drug was sufficient to cause, in rare susceptible individuals, a precipitous decline in leukocyte values, accompanied by violent signs and symptoms.[2] Furthermore, it was possible to reproduce this syndrome at any time that a small quantity of amidopyrine was readministered to individuals known to be sensitive, or to normal persons who were given plasma from an amidopyrine sensitive patient.[3] The rapid development of leukopenia suggested removal of leukocytes from the peripheral blood. In vitro demonstration of leukoagglutination or leukolysis whenever serum from an amidopyrine sensitive person was mixed with this drug, leukocytes and complement, led to the reasonable explanation that amidopyrine sensitivity was associated with an altered antigen-antibody relationship.[3]

As agranulocytosis was observed following other drugs, it soon became clear that different mechanisms were responsible for this drug reaction. Thus, thiouracil and the sulfonamides rarely resulted in agranulocytosis before 10 days of continuous treatment, and then, only after a relatively large amount of this compound was given.[4] The occurrence of leukocyte depression following a latent period has been observed in a similar fashion with the phenothiazines, such as chlorpromazine or CPZ.[5] Furthermore, cases of this sort are associated with an early decline of lymphocytes from the peripheral blood, followed by cellular depletion in the bone marrow, while large amounts of the drugs are given over a prolonged period of time. Thus, temporary aplasia of peripheral blood precursors may be related to a toxic buildup of the drug which may affect dividing blood cell precursors in the marrow. Clinical observations such as these in 24 cases of agranulocytosis induced by CPZ, plus the inability to demonstrate antileukocyte antibodies in their drug treated serum was regarded as lack of evidence to support an immuno-allergic mechanism as causative factors in agranulocytosis induced by CPZ.[5]

For these reasons, our laboratory has been concerned with the possibility of a metabolic abnormality, perhaps genetically determined, in the blood forming tissues of CPZ sensitive persons.

The important clues in this quest included lack of effect of these drugs upon mature leukocytes in the peripheral blood and the depletion of cellular elements in the bone

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Supported by Research Grant C–5524 from the National Cancer Institute of the National Institutes of Health, Education and Welfare, Public Health Service.

marrow. These suggested drug induced interference in cell division as only those cells potentially capable of dividing were affected by CPZ. More fundamentally, absence of cellular proliferation suggests a disturbance in nucleic acid synthesis as a cell divides when its complement of desoxyribonucleic acid (DNA) is doubled. Accordingly, anything which interferes with DNA synthesis could also be expected to affect cell division. For this reason, the affect of CPZ was assessed upon synthesis of desoxyribonucleic acid (DNA) and ribonucleic acid (RNA) by bone marrow cells.[6] This was compared to the effects of non-myelotoxic drugs, such as aspirin, promethazine, and diphenhydramine, in a similar test system.

In these studies, advantage was taken of the fact that during DNA synthesis, as preparation for cell division, thymidine is specifically taken up by the nucleus as a specific DNA precursor and uridine as a predominant RNA precursor. These compounds may be labeled with tritium (H^3) which is easily identified because its weak energy beta emission is readily localized as to its point source by radioautography. Accordingly, any cell which is actively synthesizing DNA or RNA, incorporates tritiated thymidine or uridine, respectively, becomes radioactive and may be recognized as such by the demonstration of silver grams overlying its nucleus by radioautography.

These studies were done by incubating heparinized bone marrow suspension with the test drugs for one hour, following which tritiated thymidine or uridine was added. The mixture was incubated for exactly 3 hours, smears of the marrow were prepared and covered with an emulsion of photographic film. After 3 to 21 days, the slides were developed in the darkroom, fixed and stained through the film with giemsa stain. Cells which had incorporated thymidine and uridine were now radioactive and could be identified as such by the varying number of grains over the nuclear area. Three types of determinations could now be made. By counting the total number of radioactive cells, it was possible to relate the percentage of radioactive granulocytes per total marrow cell or per granulocyte precursors as an index of survival of a cell population capable of synthesizing DNA and RNA. Secondly, the average number of grains per granulocyte precursor per incubation period could be identified as average rate of DNA or RNA synthesis per cell. Thirdly, by classifying the cells according to the number of grains that overlay them, it was possible to identify a population of heavily labeled, moderately labeled, and nonlabeled cells.

It was found[6] that CPZ significantly inhibited nucleic acid synthesis in the bone marrow of 75 per cent of a random hospital population. This drug inhibited nucleic acid synthesis to an even greater degree in marrow preparations taken from those individuals known to be specifically sensitive to this drug. No such inhibition was observed in marrow preparations obtained from persons while on high doses of CPZ without having developed agranulocytosis. The inhibition of DNA synthesis occurred specifically at the expense of those cells which synthesized DNA in its greatest degree.[7] In other words, the cells with the highest grain counts were eliminated, while those with intermediate grains persisted. Non-myelotoxic drugs such as aspirin, promethazine, diphenhydramine and penicillin had no inhibitory effect. Also, CPZ did not inhibit protein synthesis as evidenced by no inhibition of incorporation of tritiated leucine or $sulfur^{35}$ labeled L-cystine and methionine.[8] Marrow removed from one patient sensitive to sulfonamides was not inhibited by CPZ but instead by a sulfonamide. Two persons, known to have had aplastic anemia due to mesantoin, manifested diminished incorporation of tritiated uridine in their marrow cells by mesantoin, but no such effect on incorporation of thymidine.[9]

These studies show that CPZ specifically and directly inhibits nucleic acid synthesis in bone marrow cells of sensitive persons, and in a large segment of the population. However, they do not as yet, explain the difference between a sensitive and a non-sensitive individual, but imply that the potential incidence of myelotoxicity of CPZ may be higher than suspected if sufficiently large quantities of the drug are given for a long enough period. Furthermore, this technic may be applied to a study of other drugs potentially capable of injuring the bone marrow.

The next task confronting us is to try to identify the enzymatic step at which synthesis of DNA is depressed by drugs. This may be accomplished by observing the effect of myelotoxic drugs in a cell free system for

the synthesis of DNA. It may be possible in this way, to define potential drug sensitivity in terms of diminished enzyme activity in the marrow cells of occasional individuals. Furthermore, the means may be at hand to determine whether such altered drug reactivity is due to a hereditary transmitted defect.

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REFERENCES

1. Madison, F. W. and Squier, T. L.: Etiology of primary granulocytopenia (agranulocytic angina), J.A.M.A. 102:755, 1934.
2. Dameshek, W. and Colmes, A.: Effect of drugs in production of agranulocytosis with particular reference to amidopyrine hypersensitivity, J. Clin. Invest. 15:85, 1936
3. Moeschlin, S.. Immunologic granulocytopenia, Sang 26:32, 1955.
4. McGavock, T. H. and Chevally, J.: Untoward hematologic responses to antithyroid compounds, Am. J. Med. 17:36, 1954.
5. Pisciotta, A. V., Ebbe, S. N., Lennon, E. J., Metzger, G. O. and Madison, F. W.: Agranulocytosis following administration of phenothiazine derivatives, Am. J. Med. 15:210, 1958.
6. Pisciotta, A. V. and Kaldahl, J.: Studies on agranulocytosis; IV. Effect of chlorpromazine in nucleic acid synthesis of bone marrow cells in vitro, Blood 20:364, 1962.
7. Pisciotta, A. V.: Unpublished data.
8. Pisciotta, A. V., Ebbe, S. N., Daly, M., Ruwaldt, M., Glaser, M. and Metzger, G. O.: Studies on agranulocytosis; II. Effect of granulocytotoxic drugs upon influx of S^{35} L-cystine and L-methionine into human leukocytes, Blood 16:1456, 1960.
9. Pisciotta, A. V., Callaghan, J. L., Keller, C. and Kaldahl, J.: Effect of chloramphenicol and methyl-ethyl-phenyl-hydantoin (Mesantoin) upon nucleic acid synthesis in marrow cells. Presented at IX Congress International Soc. of Hematology, Sept. 12, 1962, Mexico, D.F.

SYMPTOMATIC ESOPHAGEAL HIATUS SLIDING HERNIA: CLINICAL, RADIOLOGIC, AND ENDOSCOPIC STUDY OF ONE HUNDRED CASES

DAGRADI, ANGELO E. and STEMPIEN, STEPHEN J., *American Journal of Digestive Diseases,* 7:613 (July) 1962.

Once considered an essentially symptomless finding, sliding hiatus hernia is nowadays considered a fairly common symptomatic condition. In a study of 100 cases the authors correlate clinical findings with endoscopic and radiologic observations.

The difficulty of diagnosing a small sliding hiatus hernia on x-ray is well known. Due attention must be given to differentiate it from a phrenic ampulla and to separate true reflux from simple chalasia. Spontaneous reduction of small sliding hernias makes their diagnosis even more difficult. Suffice it to say that even the weight of the barium meal may be enough to reduce a small hernia.

Some diagnostic criteria observed on esophagoscopy are a high gastroesophageal junction with "infolding" of the gastric mucosa with a patulous cardia through which gastric secretion freely refluxes. The gastric mucosa may be extremely edematous or atrophic with all stages in between. Small esophageal varices are common. Esophagitis may be encountered and may show wide variation in severity in the same patient at different times. Strictures are commonly observed.

In order of frequency the symptoms are: epigastric and/or substernal pain, heartburn and/or regurgitation, dysphagia, and upper GI bleeding. Some general facts are apparent from a review of the author's findings. There is no correlation between the pathologic findings and the occurrence of incidence of manifestations; dysphagia with stricture must be differentiated from carcinoma, and the presence of upper GI bleeding in a patient with a sliding hiatus hernia does not necessarily mean that the bleeding is coming from the hernia as the incidence of duodenal ulcers in patients with hiatus hernias is higher than in normal patients. The hallmark of all these manifestations is their intermittency and the unpredictability of their appearance. The size of a hiatus hernia bears no relation to the severity of its manifestations.

Factors responsible for the development of a hiatus hernia are: aging and obesity; increase in intra-abdominal pressure (pregnancy, ascites, hepatomegaly, large ovarian tumors); spasm of the esophagus with longitudinal contraction pulling the stomach into the chest (esophagitis, peptic ulcer, cholelithiasis, diverticulitis, scleroderma); and (occasionally) surgical manipulation.

Complications are esophagitis, esophageal ulcer and stricture, gastritis of the mucosa lining the hernial sac, and gastric ulcer in the sac. Upper GI bleeding is a serious and frequent complication related to dietary and alcoholic indiscretion.—*International Medical Digest* 78:486 (Nov.) 1962.

MEASLES VACCINE INFORMATION

The State Board of Health wishes to call attention to the recommendations of the Surgeon General's advisory committee on measles vaccine. Dosage indications and contraindications appear in the full text of the report which appears on pages 1112 and 1113 in the March 30, 1963, issue of *The Journal of the American Medical Association.*—DAVID R. JAMIESON, Public Health Educator, Division of Health Education.

THE NEW PRESIDENT

WILLIAM JOHN EGAN, M. D.

The newly installed president of the State Medical Society of Wisconsin, William John Egan, M.D., has a long record of service to his county and state medical societies, his community, the pharmaceutical industry, and numerous voluntary organizations on the local, state and national level.

A native of Hurley, Wisconsin, Doctor Egan is a 1916 graduate of the University of Michigan Medical School. He interned at Milwaukee Hospital and undertook a fellowship in surgery at the Mayo Clinic which was interrupted by service as a captain in the medical corps during World War I.

Doctor Egan began his practice of internal medicine in Milwaukee in 1919 and in the same year became a member of the faculty of Marquette University School of Medicine. He is currently emeritus associate professor of clinical medicine at the University and an honorary member of the faculty of the University of Guatemala.

An active member of the Medical Society of Milwaukee County, he has served on committees dealing with rehabilitation, postgraduate education, public policy, first aid and disaster, public relations, and health insurance, and also served on the society's board of directors. He was elected to the Council of the State Medical Society in 1959 and served until becoming president-elect in 1962.

Doctor Egan is a diplomate of the Wisconsin Society of Internal Medicine, and a charter member of the organization; he is also a member of the American Board of Internal Medicine. He is a fellow of the American College of Physicians, a member of the American Congress of Physical Medicine and Rehabilitation, American Rheumatism Association, Wisconsin Rheumatism Association, Milwaukee Academy of Medicine, Milwaukee Society of Internal Medicine, Alpha Omega Alpha, and Phi Rho Sigma.

Active in civic affairs, the new president has been a member of the board of directors of the Wisconsin Chapter, Arthritis and Rheumatism Foundation since its organization in 1950 and has served on its medical committee since that time. He is a past chairman of the Milwaukee County Chapter, American Red Cross, and an honorary life member of the national organization. A director of the Milwaukee Blood Bank, he is also a member of the executive committee of the Milwaukee Safety Commission, and currently serves as secretary.

Doctor Egan is president of three drug companies: Yahr Lange Drug Company, Milwaukee, La Crosse Drug Company, and Rockford (Ill.) Drug Company; and is chairman of the board of Crandon Drug Company, Miami and Fort Lauderdale, Fla.

Doctor and Mrs. Egan have two sons and one daughter, and eight grandsons and five granddaughters.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

MAY 1963

Vol. 62 No. 5

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Better Way

■ THE STATEMENT adopted last February by the Council of the State Medical Society regarding licensing of professions ancillary to medicine presents clearly and precisely the only reasonable approach to the problem. Efforts are presently being made by psychologists to obtain licensing legislation, and the question of compulsory certification by the state is once more re-opened.

Now, as in the past, the State Medical Society is opposed to extending licensure, certification or registration under Wisconsin law. Its reasons are based on a far-sighted regard for the health care of the citizens of the state. We also have reached conclusions drawn from past experience with licensure. Briefly, as the Council put it, we believe the present program of voluntary certification is adaptable to changing requirements of medical science and can, under proper conditions, assure an adequate supply of ancillary personnel of high caliber.

The State Medical Society can only recommend support or opposition to proposed legislation. It should and does insist, however, that any licensing, or compulsory certification legislation provide that the State Board of Medical Examiners retain ultimate supervision over the applicable procedure. Since the professional and technical groups seeking state licensure are sub-sciences of medicine and function in an ancillary capacity, it is essential that their certification be controlled eventually by medical personnel.

In addition, the Council of the State Medical Society recommends that the very process of licensure should pay for its own administration through adequate fees for registration or certification, and that any facultative legislation should include adequate provision for enforcement against abuses.

It is to be hoped that members of the legislature consider carefully the Council's statement. When the implications of compulsory certification for ancillary professions are clearly understood, the superficial luster of the proposals begin to dim. Far from being a minor matter affecting interprofessional relationships, the drive for license by some groups could result in serious consequences for the health care of the citizens of our state. And that is a matter the legislature should not take lightly—or dispose too quickly.—D. N. G.

Cytologic Revolution

The astonishing increase in use of cytologic methods for the detection of malignancy is well documented in this issue of the *Wisconsin Medical Journal.* That lives are being saved cannot be doubted, according to statistics shown in Doctor Van Duser's article, and the worth of the Papanicolaou smear of the cervix is chillingly highlighted by the comparatively dismal results with breast and lung cancers.

Although Wisconsin is among the leaders of states providing cytologic services to its citizens, a mere 12 per cent of its women over 20 years of age are estimated to have had cervical smears. A vast expansion of present services and the development of new ones, as pointed out by Doctor Evans, is urgently needed.

To lift this invaluable tool from the status of a diagnostic aid to a screening device will require the active participation of county medical societies. Public education programs as well as methods for reaching large numbers of asymptomatic women must be developed simultaneously. Only then will death from uterine cancer be brought to its irreducible minimum.

The formulation of future programs must inevitably be concerned with costs. Considered alone, the usual charge for a Papanicolaou smear is small enough for the peace of mind incident to a negative report. Yet its addition to the physician's fee, routine laboratory charges, chest x-ray, and the like, could have a deterrent effect. As a worthwhile public health program, cytologic services should be made available to as many as possible at a cost as low as possible.

—D. N. G.

Deluxe Chiropractic

If you think you are dismayed by what seems to be the perverse stupidity of those in high places or the self-seeking arrogance of the people who establish the conditions under which we live and work and raise our families—if your soul is almost sickened by the prospect of a universal retreat from integrity, consider for a moment what's going on at Mount Horeb in western Dane county and how a prominent Wisconsin newspaper, the *Capital Times* of Madison reports it.

According to an April 2nd story, given headline position on its State and Community News Page, the *Capital Times* informs the public that the "enactment of a spectacular new building project by G. S. Gonstead, Mt. Horeb chiropractor, is expected to transform this Western Dane community into one of the nation's centers of chiropractic treatment." It seems that chiropractor Gonstead plans to build a chiropractic clinic, whatever that might be, and a 30-unit motel. The "clinic" will have "the appearance of a jet with swept wings;" one floor will be used for seminars and the other floor will have space for eight practicing chiropractors, according to the Cap Times' reporter. The motel development will reportedly include such "public conveniences" as two restaurants, two bars and similar valuable adjuncts.

In fact, the *Capital Times* records, this complex of chiropractic construction was originally planned for downtown Mt. Horeb, but an unwillingness to comply with local building regulations compelled Mr. Gonstead to take his schemes outside the village limits.

The idea of the motel, according to the *Capital Times*, is to allow Gonstead's customers to stay close to him for as long as it takes him to "treat" them. Mr. Gonstead must be given respect for commercial enterprise if for nothing else.

But if Gonstead is respected as an enterprising cultist, what can be said about the *Capital Times* and its reporter for publishing a highly editorialized feature story about Gonstead and his works in accents of uncritical approbation? Where the Cap Times got the opinion that "enactment" of Gonstead's construction was giving to Mt. Horeb one of the nation's centers of chiropractic treatment is not indicated in the story. Nor does the reporter disclose where he got the idea that Gonstead is a "recognized authority" in the chiropractic field or who gave him the information that local business men are "delighted" over the prospect of having their

community stigmatized as a center of quackery. Reading the article conveys the very distinct impression that Gonstead himself is talking, rather than a trained, discriminating discerning reporter.

Finally, as though to complete the confusion between editorial opinion and the honest report of fact, the Cap Times alleges that the anonymous "Some," that splintered crutch of doubtful, usually dishonest reporting, "have expressed the hope that the Gonstead clinic would be to Mt. Horeb what the Mayo Brothers clinic is to Rochester, Minn." There's a gasser for you.

The distaste of the *Capital Times*, and presumably its editor and publisher, for the medical profession has hardly been a secret. In the past this newspaper, which boasts of its fearless integrity as well as its lofty standards of journalism, has seized on every pretext to denigrate doctors and their organizations. It has catered to the curious notion of ignorant people that doctors are in conspiracy against the community they seek to serve.

It is alarming when a newspaper such as the *Capital Times*, with a substantial circulation, promotes a vicious, dishonest attitude toward an entire profession. But it is terrifying when the *Capital Times* attempts to give a recognized cultist a patina of respectability by reporting his activities with editorial approval. Its Gonstead story of April 2nd does less harm to the medical profession than it does to the readers of the Cap Times who may be led, pied-piper fashion, into using the services of a chiropractor.

On the inevitable day when chiropractic stands exposed for all to see what it really is, will the Cap Times have anything to say about its contribution to the victimizing of the ignorant and the innocent? Will it finally admit that its campaign of doctor baiting has been a tragic disservice to the community?—D. N. G.

PICTURE ROUND-UP YOUR SOCIETY IN ACTION!

An all-out war on food faddists, pseudo-scientific practitioners, mechanical gadgetry, and mail order and house-to-house health frauds was started by the State Medical Society when the first Conference on Health Fads and Fallacies was held April 18–20 at the Madison headquarters.

State and national health authorities, law enforcement officials, and voluntary health agency representatives participated in the three-day conference, which brought almost 600 persons from all parts of the state and all walks of life to the Society headquarters. Special exhibits on quackery and superstition were drawn from the Food and Drug Administration, American Medical Association, American Cancer Society, American Arthritis and Rheumatism Foundation and others.

All meetings were open to the public. Courtesy luncheons were served each day. There was no registration fee. Programs were sent to 12,000 persons.

Two major objectives of the conference were: One, alert the public to the dangers of quackery and its extent in Wisconsin; and two, set the stage for more effective law enforcement through cooperation between the public, health professions, voluntary health agencies, and local, state and federal enforcement bodies.

The Society's purpose in holding the conference could not be better explained than in the following letter from a Madison woman who attended:

"I had the pleasure of attending your 3 day session on Food Fads and Fallacies. It was terrifically worthwhile. As a result, I'll save $50.00 per year on lecithin I was buying. I never have taken any medicine unless prescribed by a physician, but while in California, the food faddist friends persuaded me to try lecithin. I have sent them some of your literature to set them straight.

"Folks here say you also staged a good Health Week before I returned. At least I benefited from Food Fads. Everything was done superbly. First, the programs sent out in pretty colors were attractive and inviting. Then there was not a dull moment from start to finish! Talks were streamlined and challenging. Right length, too.

A vibrating "horse collar," purported to cure more than 50 diseases and conditions, is shown by A. Harris Kenyon, Minneapolis, district director of the Food and Drug Administration. On the left is Henry T. Scott, Ph.D., director of the biological laboratories of the Wisconsin Alumni Research Foundation, and on the right, Jerome Williamson, Chicago, an inspector for the Post Office Department. All were speakers at the conference.

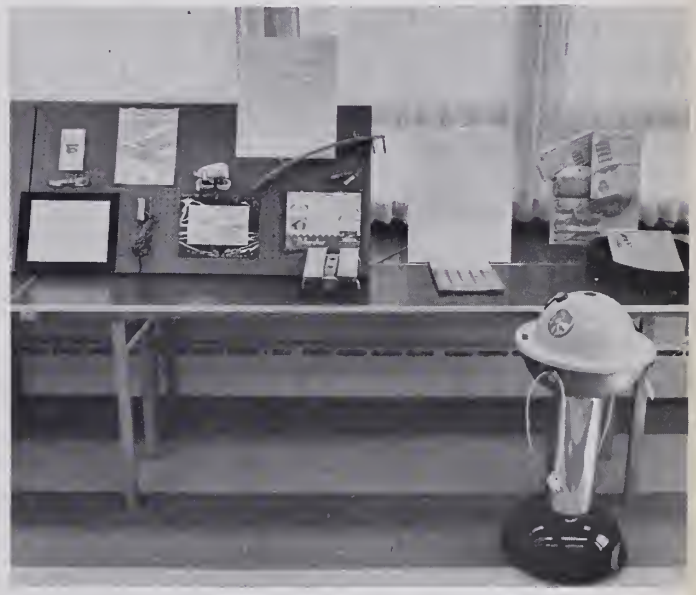
"I appreciated the right temperature of the room and the fact that there was almost no smoking. (Smoke gives me a headache so I was happy.) To be served lunch was a treat and restful. The food was delicious. So you doctors really put on a needed and informative show we'll never forget. Thanks!"

Twenty-six guest speakers covered three broad areas: Public Education for Protection Against Quackery, Health Fads and Health Careers, and Responsibility for Controlling Health Fads and Fallacies. Speakers included: The Honorable George W. Thompson, attorney general of Wisconsin, Madison; Frank Neu, public relations director, American Dairy Association, Chicago; Dorothy J. Pringle, Ph.D., professor of foods and nutrition, School of Home Economics, University of Wisconsin, Madison; Linda Allen, administrative associate, Committee on Cosmetics, AMA, Chicago;

John Guill, Jr., director, Chicago district office, FDA, Chicago; Jerry W. Walsh, regional director, Arthritis and Rheumatism Foundation, New York City; G. K. Grimm, vice-president, Better Business Bureau of Milwaukee, Milwaukee; Walter Gleason, president, Wisconsin Press Association, Clintonville; Oliver Field, director, Department of Investigation, AMA, Chicago; William F. Lemke, Jr., attorney-in-charge, Federal Trade Commission, Chicago;

H. G. De Kay, Ph.D., professor of pharmacy, Purdue University, Lafayette, Ind.; Dr. W. W. Bauer, director emeritus, Department of Health Education, AMA, Chicago; Dr. Walter C. Alvarez, professor of medicine emeritus, University of Minnesota; Donald N. McDowell, director, State Department of Agriculture, Madison; Dr. Morris Cohn, New York City; Dena Cedarquist, director, Food and Nutrition Department, Michigan State University, Lansing;

Methods of exposing quackery are discussed by Dr. W. W. Bauer, director, Department of Health Education, American Medical Association, Chicago, and Dr. Walter C. Alvarez, professor of medicine emeritus, University of Minnesota. Doctor Alvarez, a nationally famous lecturer and author, and Doctor Bauer were featured speakers.



A selection of quackery materials seized in recent years by the Food and Drug Administration were exhibited. These exhibits are currently on display at the Museum of Medical Progress in Prairie du Chien.

Dr. N. A. Hill, past president of the State Medical Society, Madison, explains a quackery device to the Honorable George W. Thompson, attorney general, and Frank Neu, public relations, director of the American Dairy Association. Thompson and Neu were featured speakers.

A health foods store was set up to emphasize the numerous faddism products and literature sold and distributed under the guise of health improvement. Staff members, Mary Conway, Bernadette Lucey, and Judi Soehli, demonstrate a purchase at the store.

Professor H. George De Kay, Purdue University, shows old-time patent medicine bottle to William F. Lemke, Jr., attorney-in-charge, Federal Trade Commission, Chicago. Both men were featured speakers.

Medical superstitions of years gone by often reappear as the basis for modern health fads and fallacies. Below Dr. V. S. Falk, medical editor of the *Wisconsin Medical Journal*, Edgerton, and Warren Resh, assistant attorney general, examine a unicorn horn replica. The horn of the mythical animal was prescribed in ancient times for a great variety of illnesses. Doctor Falk was moderator for one of the sessions and Mr. Resh was a speaker.

Fake machines, seized in recent years by the Food and Drug Administration, were on display. At the left, Bernadette Lucey and Judi Soehle, staff members, demonstrate the "neuralinameter," a worthless machine seized in the state in 1958.

Dr. Robert J. Samp, medical director, Wisconsin Division, American Cancer Society, Madison; Henry T. Scott, Ph.D., director, Biological Laboratories, Wisconsin Alumni Research Foundation, Madison; Jerome Williamson, postal inspector-in-charge, Post Office Department, Chicago; A. Harris Kenyon, director, Minneapolis district, FDA, Minneapolis; B. H. Kettlekamp, Ph.D., president, State Board of Examiners in Basic Sciences, River Falls; Dr. T. W. Tormey, Jr., secretary, State Board of Medical Examiners, Madison;

Warren Resh, assistant attorney general of Wisconsin, Madison; F. J. Griffith, deputy director, State Department of Agriculture, Madison; Dr. Robert G. Zach, chairman, Commission on Public Policy, SMS, Monroe; Dr. H. E. Jervey, Jr., treasurer, Federation of State Boards of Medical Examiners, Columbia, S. C.; Francis J. Wilcox, president-elect, State Bar of Wisconsin, Eau Claire.

Moderators for the conference were Doctors J. H. Houghton, councilor of SMS, Wisconsin Dells; William T. Russell, member, Commission on Public Policy, SMS, Sun Prairie; and Victor S. Falk, medical editor, *Wisconsin Medical Journal*, Edgerton. The Society's president at that time, Dr. N. A. Hill, presided as host for the conference.

The Society received cooperation from a number of sources including the American Cancer Society's Wisconsin Division, Wisconsin Chapter of the Arthritis and Rheumatism Foundation, Wisconsin Diabetic Association, Wisconsin Pharmaceutical Association, American Dairy Association of Wisconsin, Better Business Bureau of Milwaukee, and allied health groups.

Minutes of Council Meeting

Minneapolis, November 9–10, 1962

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 8:25 p.m. on Friday, November 9, 1962, at the Hotel Leamington in Minneapolis, site of the North Central Conference on November 10–11.

All councilors were present except Doctors Blanchard, Bell, Van Hecke, and Past President Lokvam; except that Doctor Chojnacki was present Friday only, and Doctors Willson and W. J. Houghton were present Saturday only, having been delayed by a late train arrival. Officers and others present were Doctors Hill, Egan, Callan, Carey, Simenstad, and Hildebrand; Messrs. Crownhart, Thayer, Toser, Reynolds, Murphy; Mrs. Anderson and Miss Pyre.

2. Approval of Minutes

On motion of Doctors Schulz-Curran, carried, minutes of the July 1962 meeting were approved, it being noted that in deference to Senator Proxmire, his letter of August 10 in response to the July communication from the Council was incorporated in the minutes.

3. Public Policy Report

The Council had received a comprehensive report from the Commission on Public Policy covering its legislative and other proposals for 1963.

(a) On motion of Doctors Mason-J. H. Houghton, carried, the committee's recommendations with respect to the Basic Science Law were approved.

(b) On motion of Doctors Nordby-Chojnacki, carried, its recommendations relating to the State Board of Medical Examiners were approved.

(c) On motion of Doctors J. H. Houghton-James, carried, the recommendations regarding use of the title "Doctor" were approved.

(d) On motion of Doctors Nordby-Schulz, carried, the committee's recommendations with reference to chiropractic were approved.

(e) On motion of Doctors Chojnacki-Curran, carried, the proposed Conference on Health Fads and Fallacies was approved, including the preliminary fiscal notes covering the cost of the conference and other recommendations which involved financing.

On inquiry, the staff explained that outside financial assistance could not be sought until the recommendations were approved.

4. Podiatry

The Executive Committee reported its actions on October 27 that costs related to the hearing called by the Insurance Commissioner with respect to podiatry benefits in health insurance contracts should be borne by the State Society dues structure; and that legal counsel be authorized to retain "of counsel" in this action.

The Secretary reported generally as to legislation which will be drafted through the Commission on Public Policy with reference to the practice of podiatry.

Mr. Murphy presented a legal opinion which it was proposed be sent to Society members on the right of dentists and podiatrists to hospital staff appointments, and the professional and legal responsibility of the physician after reference of a patient to a limited licensee such as a dentist, or to one who practices under a certificate, such as a podiatrist or a physical therapist.

On motion of Doctors Nordby-James, carried, the proposed bulletin was approved.

5. Menominee County Health Survey

The recommendations of the committee, appointed in May at the Council's request, were presented in detail. In general, they were to continue the project under the guidance of the Charitable, Educational and Scientific Foundation of the Society, with a permanent committee in direction including representation from the Shawano County Medical Society. To assure continuation of the study, an appropriation of $2,000 from the State Medical Society to the Foundation was recommended, and funds from other sources will be sought. The committee advanced a number of suggestions to follow up in an effort to alleviate the health care problem.

On motion of Doctors Curran-Schulz, carried, the report and recommendations were approved.

On inquiry, the Secretary said that the Council's approval of the requested appropriation in effect became a mandate upon the staff and Finance Committee to make appropriate adjustments in the 1963 budget to provide this amount, should adequate financing from other sources not be available.

6. Report of Executive Committee

(a) Meeting with representatives of the Section on Surgery

Several actions of the Section in May had been the subject of a joint meeting in October, including the Section's position with respect to a resolution introduced by the Section on General Practice in May and referred to the Council, and action by the American Medical Association in June, 1961, with respect to the employment of surgical assistants.

Following discussion of these matters by the Council, and on motion of Doctors Hollenbeck-Chojnacki, carried, the entire subject was referred back to the Executive Committee for further discussion and report back to the Council.

There was general agreement with the suggestion that through mechanisms of the committee and counsel, a forthright statement applicable in Wisconsin, without regard to actions elsewhere, be prepared by the time of the 1963 annual meeting if possible.

(b) University of Wisconsin Research Project

The Council was provided with a formal request from the University of Wisconsin for financial support of a research project on "Teaching Resources in Health Education" at a cost of $2,500.

The Executive Committee had reviewed the request and felt it was a highly worth-while proposal for financing through an appropriation to the Foundation in 1963.

On motion of Doctors Dessloch-Kief, carried, support of the research project was approved.

(c) Milwaukee Blood Center, Inc.

On motion of Doctors J. H. Houghton-Hollenbeck, carried, the Council endorsed the following resolution concerning blood insurance:

"The only source of blood is human beings. Adequate supplies of blood and its derivatives for use in transfusions can be obtained only if men and women cooperate by volunteering in sufficent numbers to meet demand.

"Dollars cannot be transfused and dollars will not purchase adequate numbers of blood donors.

"Individuals or groups who seek dollar coverage for blood in health insurance are asking a fringe benefit that cannot be guaranteed.

"They must give blood so they may receive it when necessary.

"For your own protection, accept hospital insurance covering insurable costs. Do not ask for blood insurance; reject it if it is offered. There is no substitute for blood donation."

(d) Public Forum at Annual Meeting

On motion of Doctors Nordby-Curran, carried, the Council approved consideration of arranging an evening meeting for public attendance during the Annual Meeting in Milwaukee, in 1963 if possible, utilizing one or more guest speakers on some appropriate topic.

7. Management Survey

Doctor Callan presented a petition signed by one physician which he had received for the call of a special meeting of the House of Delegates. There was lengthy discussion of the fact that the survey was not completed; that no progress report had been made to the Council; of the substantial costs involved in a special session and that they are called, when the House is not in session, by the Council on its own motion or upon petition by the designated number of delegates. The Council then took the following action:

On motion of Doctors Dessloch-Ekblad, carried, the report of Booz, Allen and Hamilton, when submitted, will be copyrighted by the State Medical Society; it will be delivered to management; and it will also be reviewed by independent legal counsel before it is made public.

The Council recessed at 12:10 a.m. and reconvened at 9:10 a.m. on Saturday, November 10.

8. Report of Committee on Economic Medicine

On motion of Doctors Willson-Schulz, carried, the Council accepted the committee's report that it had tabled, after study, the proposal that the State Medical Society establish a group comprehensive professional liability insurance program for its members. The committee reported that it had reviewed previous studies of the Society on the subject and concluded there was no additional advantage to members over the present individual approach.

9. Forthcoming AMA Meeting

There was discussion with the delegates present, without action, of matters anticipated to be taken up at the November meeting.

10. Recommendations of Commission on State Departments

(a) On motion of Doctors Willson-Nadeau, carried, the Council returned for further exploration the question of the Society supporting legislation, referred to as an implied consent law, to establish 0.10 per cent blood alcohol content as prima facie evidence of being under the influence of alcohol.

(b) On motion of Doctors Willson-J. H. Houghton, carried, the Council accepted the recommendation that the Division on Maternal and Child Welfare, in cooperation with the Bureau of Maternal and Child Health of the State Board of Health, study the advisability of setting up two pilot courses for obstetrical nurses to provide specialized training in obstetrics and delivery in emergency situations.

11. New Business

(a) Zor Shrine Burn Center

Doctor Hill reported the possibility of the Shrine establishing one of three centers for treatment and research in burns at the University of Wisconsin in Madison, and that support in principle from the State Medical Society was desired by those seeking its location here. Doctor Hill proposed to write a President's Page on the subject for the Wisconsin Medical Journal.

On motion of Doctors Nordby-Willson, carried, the Council commended the effort and offered cooperation with the Shrine in any facility it desires to set up in Wisconsin.

(b) Membership applications from osteopaths

A councilor reported that a county society in his district had received several applications for membership from osteopaths receiving a doctor of medicine degree from the California College of Medicine, recently accredited by the American Medical Association.

No formal action was taken by the Council, pending staff review of factual circumstances and a report from the Planning Committee which has the general subject under consideration. However, there was general agreement that any physician applying for membership as a doctor of medicine must, in fact, have earned the degree from a recognized college and not on a retroactive basis.

(c) State administrative rules

On motion of Doctors Nordby-Schulz, carried, the Council advised that an administrative rule of the State Board of Health of concern to the Division on Maternal and Child Welfare should be incorporated in the total study of administrative rules rather than made a separate matter for public hearing.

12. Adjournment

The Council adjourned at 10:35 a.m. on Saturday, November 10, 1962.

C. H. Crownhart
Secretary

Approved:
James C. Fox, M. D.
Chairman

the wisconsin medical journal

VOLUME 62/NUMBER 6 JUNE 1963

President's Message to the House of Delegates

By W. J. EGAN, M. D., Milwaukee, Wisconsin

■ LATE ON the night of June 23, 1953, the late Robert Irwin, president, asked me to look into the position and the prestige of the Medical Society of Milwaukee County. Next month will mark the end of an intensive ten-year study of organized medicine at the county and state levels.

Since last May when you honored me by election to be "the real head of the profession," I have attended every meeting, save one, of our state society.

Therefore, I have chosen to discuss with you various impressions of physicians' behavior in meeting the problems of organized medicine. This subject is most timely for during sessions we may have to face many complex situations. These problems may call for sound decisions to resolve complex questions in a most medical statesman-like manner.

You delegates, chosen by your own immediate colleagues, are officially second in authority in our society. Actually and practically you are first in power, and able to cope with any and all situations. You derive your power from the Article which directs that you "shall be the legislative body of the society."

It is so paradoxical that we physicians are so often told that we are inept in organizational, managing or administrative affairs. Management of any activity in this country chiefly depends on the handling of people. What profession even approaches ours in tradition, background, education, training, practice, stamina, hours of work and study, charity, philanthropy, principles of diagnosis, therapeutics, research; and ethical behavior!

What are the barriers, blocks, and other characteristics that appear to impede our success in management or medical administration?

Rather common is evidence of little or no interest and of very limited attention to extra-medical matters. Apathy is common. Complacency to the point of professional tranquility is evident.

All too often we tend to make decisions and recommendations—about extra-medical points—by methods that are "taboo" in our daily medical practice. This is: We make presumptive diagnoses and palliative recommendations, and immediately slide back into our care of the sick.

Presented before the House of Delegates at the 122nd annual meeting of the State Medical Society, May 6, 1963, Milwaukee.

Another fairly common barrier is our attitude toward "team-work." There are now about 35 specialties in medicine, and about 50 other professions, vocations and workers engaged in health practices. We universally render lip-service to the idea of team-work—but, all too frequently, we individually plan the plays and call the signals.

For the purpose of diverting this phase of the discussion, here are a number of statements from surveys of seven other medical societies. These were answers to the question: "What is wrong with medical administration?" These are not generalizations—but are specific statements.

"*Policy*—wavers, is vague and ill-defined."

"Many deficiencies, wasteful and other harmful practices are traceable to physician members."

"Physicians are basically individualistic, and usually not experienced in administration."

"Physicians often are the sharpest critics of their societies." Many criticisms are ungracious, and bluntly given. Examples: "bumbles"—"picayune in every way"—"stagnant for years"—"horse and buggy basis"—"run like a country store"—"penny-pinchers"—"wasteful"—and many others.

I earnestly believe that we physicians are ideally suited for administrative management. We are trained to make decisions and to act after we learn the history, data, facts, findings, and the experience of others.

A sound organization, functioning competently, is not the end for us but the means for fulfilling the goals of our society.

Successful management, with complete adherence to our principles and discipline, is essential to prevent complete disruption.

In closing, I reiterate that the management of people is part and parcel of a physician's daily life.

In the "art" of medicine, persuasion is the dominant factor—underlying the practice of medicine—that moves people to action.

REPORT ON IODINE 131 IN MILK

Extremely low daily averages of iodine 131 were detected in Wisconsin milk again during the month of May, the State Board of Health announced June 10. These averages, reported from the state's six sampling stations, and expressed in micromicrocuries per liter of milk, were:

Station	*Micromicrocuries*
Eau Claire	5
Green Bay	5
La Crosse	1
Madison	3
Rice Lake	2
Wausau	6

Another sampling station, located at Milwaukee as part of the U. S. Public Health Service network, showed an average daily iodine 131 content of five micromicrocuries for the month of April. The May readings at this station will not be available until later in June after they have been processed by the Public Health Service.

The present readings at the six state stations, as well as the one at Milwaukee, provide no cause for concern over the iodine 131 content of our milk, the board notes.

Federal radiation standards, it was explained, require action only when the average per person intake of iodine 131 exceeds 100 micromicrocuries per day over a one-year period.

Despite this fact, the board emphasized that it is maintaining a careful watch for any real threat to the health of Wisconsin citizens as a result of iodine 131 in milk.

Any necessary action, board officials add, will be taken immediately to prevent health hazards from occurring.

The board is watching developments in cooperation with the State Department of Agriculture and the University of Wisconsin's College of Agriculture so that these agencies may be prepared to act together in the best public interest should this become necessary.

FILM: Role of Urine in Diagnosis

A filmstrip, "The Role of Urine in Diagnosis," Part II, provides basic orientation on the identification and clinical meaning of many urine substances. It is intended to aid medical technologists, medical students, interns, residents, and practicing physicians to gain a better understanding of the basic methodologies and interpretations of this important area of clinical pathology. It is one of a series of four filmstrips on urinalysis and renal function produced under the direction of the American Society of Clinical Pathology, and made available to the medical profession by the Ames Company.

SPECIAL TO THE JOURNAL

Medicolegal Responsibility in the Prevention of Automobile Accidents

By HERMAN A. HEISE, M.D., Milwaukee, Wisconsin

■ IF AN ATOMIC BOMB were exploded over a city the size of Milwaukee killing 40,000 men, women, and children, and seriously injuring every survivor in the city and suburbs, the unspeakable horror would arouse the world to try to find the means of preventing a similar catastrophy. However, when the same degree of death and injury, caused by the automobile, is spread over a twelve-month period throughout the entire country, when a hundred or so are killed and a few thousand crippled daily with monotonous and even predictable regularity, the average citizen isn't even mildly aroused. Possibly the knowledge of the *cost* of these accidents might impress those who are not concerned with death and crippling injuries. In Chicago alone, the annual cost of traffic accidents is estimated at more than 115 million dollars. Cost figures include wage loss, medical expense, and overhead cost of insurance. (TRAFFIC SAFETY, January 1963, pp. 16–18).

If the automobile carnage were inevitable, this equanimity might be excusable. The close relationship between these accidents and alcohol indicates that such is not the case. Four independent surveys in this regard have been made in different parts of the country. All agreed that alcohol was involved in one-half of the accidents, and that in one-third of the accidents there was no doubt that the responsible individual, driver or pedestrian, was definitely under the influence of alcohol. The most recent survey is also the most significant. Dr. William Haddon, investigating single vehicle accidents, which obviously involved just one responsible person, found that approximately three out of four of the drivers had been drinking, and half of them were definitely intoxicated. On the other hand, in 1931 when very few chemical tests were available, W. W. Matthews, Commissioner of Road Traffic of Pennsylvania, stated that only one per cent of accidents were reported as involving alcohol. Since that time, however, the National Safety Council's figures regarding the role of alcohol as reported in traffic accidents have risen, due to chemical evidence, but the true figures will not be known until guesswork regarding intoxication is confirmed by chemical tests. It is obvious that the death and injury toll could be materially lessened by eliminating the alcohol factor. This can be done and is being attempted by education and enforcement. Intelligent individuals will profit from the knowledge that judgment, eyesight, and coordination are affected by alcohol, and will therefore avoid drinking and driving. Others who believe that alcohol does not affect them, or who may even insist that alcohol steadies the nerves and stimulates them, must be recognized and punished if they insist on risking not only their own lives but also the lives of innocent passengers or pedestrians.

Although the recognition of alcoholic intoxication is a matter of common knowledge, the proving of the condition is difficult. When the neatly dressed, well-mannered individual appears in court and explains that he had but two beers and that any unusual behavior at the time of his arrest could be accounted for by illness or from righteous indignation over his arrest, the members of

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Doctor Heise was Chairman of the Committee on Medicolegal Problems, American Medical Association, 1952–1962.

AUTHOR'S NOTE: Some of this material has been quoted from the Manual on Chemical Tests for Intoxication which has been prepared by the Committee on Medicolegal Problems, American Medical Association.

the jury are understandably impressed and frequently return a "not guilty" verdict.

Would a physician examining the man at the time of the arrest be able to prove intoxication? It would seem to be one of the easiest diagnoses he could make, and yet it is one of the most difficult to substantiate in court. The person may have been obviously intoxicated, but how can the doctor prove that the accused was not suffering from a traumatic brain injury, diabetes, multiple sclerosis, or any of more than a hundred other ailments having symptoms which resemble those of alcoholic intoxication? On the other hand, the person who is being examined by the physician may have lost 50 per cent of his ability to drive a car; but being a person of unusual ability, he may still be able to give a good account of himself while being examined. It is obvious that he would not have been arrested and considered to have been under the influence of alcohol if his actions at the time of arrest had not suggested intoxication; but the presence of the examining doctor usually has a sobering influence on the accused so that he may give the impression, for a time at least, of being sober.

The difficulties of diagnosis by a casual physical examination would be almost insurmountable if no other type of examination were available. For more than 50 years, thousands of experiments have been performed on persons before and after taking alcohol; and the obvious effects of alcohol have been observed. In addition, numerous tests involving judgment, hand-eye coordination, and even the actual driving of cars under carefully controlled conditions, have been performed to observe the deleterious effects of alcohol. All of these tests were performed with simultaneous measurements of the amount of alcohol in the body as determined by chemical examinations of the blood, breath, urine and/or saliva. The conclusions from these experiments were that every individual who had certain levels of alcohol in his body fluids was under the influence of alcohol since he had lost, to a measurable extent, some of that clearness of intellect and self-control that he would otherwise have possessed. By performing chemical tests for intoxication the diagnosis becomes so definite that guesswork disappears. The test then is invaluable to exonerate the person who had not been drinking, or the person whose blood alcohol level was so low that his ability as a driver would not have been materially impaired, or to prove that the individual was under the influence in spite of false defenses.

What Is Intoxication? In order to interpret the results of chemical tests for alcoholic intoxication, it is obvious that we must define intoxication. This condition has been considered to be present according to some authors only when there has been obvious mental confusion and/or muscular incoordination, while others have considered that a person is under the influence of alcohol as soon as only slight measurable neurologic deterioration can be demonstrated. The same person simultaneously examined by two doctors may be considered culpable by one and innocent by the other, depending upon the doctor's criteria for intoxication.

It is obvious, then, that all arguments are fruitless unless we agree as to what is meant by "under the influence." We are in favor of any definition which adequately describes this condition and which can be used to convict the guilty and free the innocent. The same definition should apply in all states and preferably in all countries. At the present time we have many definitions of intoxication. To be guilty in California the individual must be so affected that he is unable to operate his vehicle in the manner of an "ordinarily prudent and cautious person in full possession of his faculties." Dr. Henry Newman interpreted this to mean that a person should not be penalized unless the alcohol had lowered his driving ability below that of the poorest licensed driver on the road. According to this definition it is extremely difficult to prove intoxication. The California law at one time exonerated the superior individual who in spite of some loss of his driving ability due to alcohol was still a better driver than most ordinary drivers. On the other hand this superior Californian would not have fared as well if scrutinized according to the laws of Arizona. Because of the difficulties of proving "under the influence" of alcohol, the National Safety Council and the American Medical Association have urged the adoption of the following definition of the Supreme Court of Arizona:

> The expression "under the influence of intoxicating liquor" covers not only all the well known and easily recognized conditions and degrees of intoxication but any abnormal mental and

physical condition which is the result of indulging in any degree in intoxicating liquors, and which tends to deprive him of that clearness of intellect and control of himself which he would otherwise possess. If the ability of the driver of an automobile has been lessened in the slightest degree by the use of intoxicating liquors, then the driver is deemed to be under the influence of intoxicating liquor. The mere fact that the driver has taken a drink does not place him under the ban of the statute unless such drink has some influence upon him lessening in some degree his ability to handle said automobile.

Steffani v. State, 42 Pac. (2nd) 615.

Proof of Alcoholic Intoxication is Difficult. Now where does the doctor fit in with the diagnosis of intoxication? Suppose that you are called upon to examine a man who is obviously drunk. You could make a careful examination and decide that his impairment is caused by alcohol—and that he is definitely intoxicated. However, (hang on to your ego) *any* person is legally qualified to testify as to the sobriety or state of intoxication of his fellow man without the benefit of a degree in medicine and without the necessity of examining the accused. In fact, one glance may be sufficient to satisfy the witness that a person is drunk or sober and his testimony is acceptable in courts of law. The doctor's work is not that simple. He knows that there are about 200 medical conditions which have symptoms in common with those of alcoholic intoxication; and that the "odor of alcohol" on the breath is an unreliable symptom, since *pure* alcohol in the concentrations which may be found on the breath has no odor. In spite of obvious intoxication, his final diagnosis depends on the chemical test for alcohol. Just as he would hesitate to diagnose poisoning by arsenic or strychnine without the benefit of chemical tests, so he would have to make his final diagnosis regarding alcoholic intoxication on the finding of alcohol in the body fluids or breath in sufficient quantities to account for the mental and physical abnormalities. About 25 years ago committees of the American Medical Association and of the National Safety Council suggested standards for the legal interpretation of chemical tests which have now been accepted in almost all the States of the Union.

A. M. A. Recommendations. The following recommendations were agreed upon by committees of the National Safety Council and the American Medical Association:

(1) Although there is no minimal figure which can be set at which there will be absolutely no effect from alcohol, the committee recommends that persons with a concentration of alcohol of less than 0.05% by weight in blood or its equivalent in urine, saliva, or breath should not be prosecuted for driving while under the influence of alcoholic liquor.

(2) Between 0.05 and 0.15%, a liberal, wide-zone, alcoholic influence usually is present, but courts of law are advised to consider the behavior of the individual and circumstances leading to the arrest in making their decision.

(3) At 0.15%, or above, there is definite evidence of "under the influence," since every individual with this concentration would have lost to a measurable extent some of that clearness of intellect and control of himself that he would normally possess.

These limits were purposely made liberal so that no injustice would be done to the person with unusual tolerance. In order to obtain a blood alcohol level of 0.05%, a 150-lb. (68-kg.) person would have to accumulate 1 fluid oz. (30 ml.) of pure alcohol in his body. To do this he would have to drink at least the equivalent of 2 oz. of 100-proof liquor. This same person would have to accumulate 3 oz. of absolute alcohol to reach a blood alcohol level of 0.15%.

Tolerance To Alcohol. Arguments regarding the validity of chemical tests almost always follow this line. "How can these tests be of value when I know lots of people who are perfectly sober after downing a 'fifth' and some who are drunk when they smell the cork?" This has been answered: "The end result depends on the starting point; some people are half drunk when they are sober." Assuming that tolerance means the ability of brain tissue to resist the effect of a given tissue concentration of alcohol, there is little difference among individual human beings. All persons show some impairment in driving ability at a blood alcohol concentration of 0.10%, and in some this ability is impaired at a level as low as 0.02%. Regardless of tolerance, the fatal concentration is 0.6% to 0.8%. The apparent behavioral differences

EDITOR'S NOTE: Section 939.22(42) Wisconsin Statutes, 1961, provides: "'Under the influence of an intoxicant' means that the actor's ability to operate a vehicle or handle a firearm is materially impaired because of his consumption of an alcoholic beverage, a narcotic drug or other intoxicating substance."

in persons of about the same weight who drink equal amounts of alcohol may be explained in several ways. A well-balanced person who has consumed some alcohol could lose half his driving ability and still be a better driver than a slower reacting or poorly adjusted driver. Also a person who is accustomed to accomplish certain tasks which can be performed automatically, such as walking or driving a car, can still perform these functions fairly well even if he is somewhat under the influence of alcohol, although he would be unable to cope with an unexpected emergency. Furthermore, an experienced drinker has learned how to counteract some of the adverse effects of alcohol; whereas a novice, faced with the same situation, would be less capable of compensating for the alcohol-imposed handicap.

In 1939 and again in 1945 the House of Delegates of the American Medical Association approved the enactment of state legislation establishing 0.15% by weight of alcohol in a person's blood as the point above which he will be presumed to be under the influence of intoxicating liquor. The recommended figure is now 0.10%.

Another change in statutes is imperative. We have been reporting alcohol percentages in body fluids "by weight" which assumes that these fluids have been weighed. Weighing is not practical since the specific gravity of body fluids varies naturally, and because added anticoagulants and preservatives increase the specific gravity of the specimens to be analyzed, without affecting the volume. Alcoholic intoxication is proportional to the alcohol in the *water* of the body, so that the *volume* of the fluid to be analyzed is important, *not its weight*. The American Medical Association and the National Safety Council are therefore recommending the adoption of the same method of designating alcohol percentages as are used for chemical analyses of other ingredients of the blood, namely *milligrams per 100 milliliters* (mg./100 ml.). This change of reporting percentages avoids decimals and is scientifically accurate. There should be no difficulty in making the change in statutes; e.g., .05 per cent weight per volume becomes 50 mg./100 ml.; .10 per cent, 100 mg./100 ml. An additional advantage of the improved method of reporting percentages is the ease of remembering that 100 mg./100 ml. is prima facie evidence of intoxication.

One of the greatest difficulties in obtaining convictions is the ever growing knowledge that it is almost impossible to prove intoxication without the chemical certainty of the nature of the intoxicant. More and more persons who are obviously intoxicated still retain enough mentality to refuse a chemical test. The accused then is usually exonerated, since there is no proof of *alcoholic* intoxication, and since a doctor might testify that the behavioral abnormalities observed were probably caused by medical conditions or prescribed medicines.

Implied Consent Law. Unless the chemical test program can surmount the outmoded legal obstacles which are looming in its path, drunk driving will go on without restraint. This problem has been studied by the American Medical Association, the American Bar Association, and by the National Safety Council. The implied consent law is based on the premise that driving a car is a privilege granted by the State and that this privilege may be withdrawn by the State.

The following is a summary of the new provisions in the Uniform Vehicle Code recommended by the Committee on Alcohol and Drugs of the National Safety Council (submitted by Robert L. Donigan, Chairman, Subcommittee on Legal Matters):

1. Any person operating a motor vehicle upon the public highway shall be deemed to have given consent to a chemical test of his blood, breath, or urine, if he is arrested for any offense arising out of acts committed while driving or in actual physical control of a motor vehicle while under the influence of intoxicants;

2. The test is to be administered at the direction of an officer having reasonable grounds to believe the motorist was driving or in control while under the influence;

3. The type of test is to be determined by the department employing the officer;

4. Consent is effective and continues even if the motorist is unconscious or dead;

5. If the motorist refuses to submit to a chemical test, no test shall be given but the officer is to fill out a sworn report to that effect and it is to be sent to the state motor vehicle administrator;

6. Upon receipt, the administrator must revoke the driving privilege of the motorist;

7. The motorist then must be given an opportunity to be heard before the administrator as to whether (a) the officer had reasonable grounds to believe the motorist was driving or in control while under the influence, (b) he was placed under

arrest, and (c) he refused to submit to a chemical test;

8. The administrator is then to rescind or sustain the order of revocation;

9. If the order is sustained, the motorist then has the right to appeal to the state court of general jurisdiction for a review of the administrator's action;

10. If the order of revocation is sustained, the motorist cannot apply for a new license until after a lapse of at least six months after date of revocation.

(Note: Attention is invited to the fact that authority to revoke for refusal to submit to a chemical test is not dependent upon the outcome of any possible prosecution for an offense arising out of the act of driving or being in control while under the influence.)

Other provisions in the Code relating to the implied consent features are:

1. In order to be considered valid, chemical tests must be conducted according to methods and by persons approved by the State Department of Health;

2. Blood specimens can be withdrawn only by physicians, registered nurses, or other qualified persons;

3. The motorist may have a chemical test administered by a person of his choice in addition to the test administered at the direction of the officer;

4. Upon his request, the motorist or his attorney shall be entitled to full information relating to the test administered at the direction of the officer;

5. Evidence of refusal to submit to the test is admissible in subsequent civil or criminal action.

This is an appropriate time and place to once again urge all persons interested in promoting this type of legislation in their states to stand fast in recommending these national uniform standards. In those states where the legislatures have strayed from uniformity, law enforcement officials are already running into trouble. As an example, the Vermont implied consent statute provides that: "Only a physician acting at the request of an enforcement *officer of the department of public safety* may withdraw any blood of any person submitting to a chemical test . . .". Thus a municipal police officer, whose department wants to use blood tests and have the results admissible in court, would have to call in a state police officer to make the request of the doctor who was to withdraw a specimen of blood from the motorist whom the municipal officer had arrested for driving while under the influence of intoxicants.

The Doctor's Legal Status Regarding the Removal of Blood Specimens. Problems of liability for the physician who removes blood for a test are adequately covered by the New York law. The law was amended in 1958 to include the following provisions:

3a. No person except a physician acting at the request of a police officer shall be entitled to withdraw blood for the purpose of determining the alcoholic content therein. This limitation shall not apply to the taking of a urine, saliva or breath specimen.

b. No physician shall be sued or held liable for any act done or omitted in the course of withdrawing blood at the request of a police officer pursuant to this section.

c. Any person who may have a cause of action arising from the withdrawal of blood as aforesaid, for which no personal liability exists under paragraph b of this subdivision, may maintain such action against the state if the physician acted at the request of a police officer employed by the state, or against the appropriate political subdivision of the state if the physician acted at the request of a police officer employed by a political subdivision of the state. No action shall be maintained pursuant to this paragraph unless notice of claim is duly filed or served in compliance with law.

d. Notwithstanding the foregoing provisions of this subdivision, an action may be maintained by the state or a political subdivision thereof against a physician for whose act or omission the state or the political subdivision has been held liable under this subdivision, to recover damages, not exceeding the amount awarded to the claimant, that may have been sustained by the state or the political subdivision by reason of gross negligence or bad faith on the part of such physician. (As amended by Chapter 666, Laws of 1958. Effective July 1, 1958).

The Uniform Chemical Tests for Intoxication Act contains the following provision:

(Consent of Person Incapable of Refusal Not Withdrawn.) Any person who is dead, unconscious or who is otherwise in a condition rendering him incapable of refusal, shall be deemed not to have withdrawn the consent provided by Section 1 of this act and the test or tests may be given.

Attorney Richard P. Bergen, Executive Secretary of the American Medical Association Committee on Medicolegal Problems concludes: "I believe that these statutory provisions will, if enacted, provide adequate protection for a doctor who draws blood for a test at the request of a police officer from either a living person or a dead body. It might, I believe, be quite appropriate for the Committee to consider asking the House of Delegates of the American Medical Association to approve the Model Act, provided it is amended to include a provision similar to the New York law."

Conclusions. It is impossible to adequately diagnose drunkenness without the confirmation of a chemical test. Refusal to take the test usually results in acquittal. The implied consent law is necessary to keep the intoxicated driver off our highways.

Persons who are concerned about our constitutional rights regarding self-incrimination should be reminded that these rights refer to *verbal* utterances and not to such acts as the taking of fingerprints, blood tests, footprints, and chemical analyses. In addition to the American Medical Association, the implied consent law is sponsored by the American Bar Association and the National Safety Council. Ten states have already adopted this type of legislation. Will Wisconsin lag behind?

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425 East Wisconsin Avenue (2).

Find your future in the HEALTH FIELD

. . . a career guide

"Find your future in the health field," urges a new brochure published recently by the Wisconsin Health Council, Inc. The brochure, developed with the assistance of the State Medical Society, contains information on 26 careers in health.

The publication is unique in its presentation. It is intended to supplement existing careers materials, and gives factual and statistical information on personal qualifications, educational requirements and opportunities, and employment possibilities in each of the fields. It places emphasis on Wisconsin.

Careers covered are: physician, registered nurse, licensed practical nurse, dentist, pharmacist, veterinarian, public health administrator, public health nurse, health educator, health sanitarian, sanitary engineer, biostatistician, industrial hygienist, hospital administrator, physical therapist, occupational therapist, medical technologist, medical social worker, medical and dental assistant, medical secretary, dietitian, cytotechnician, dental hygienist, speech and hearing therapist, medical record librarian, and x-ray technician.

Copies are being distributed to guidance councilors in every Wisconsin school, and individual copies will be available from the Wisconsin Health Council to youngsters interested in health careers.

Supplies will also be available to physicians who participate in career days in their local schools; they may be obtained by writing the State Medical Society, 330 East Lakeside Street, Madison.

The Wisconsin Health Council, which published the brochure, was formed in 1948 to stimulate citizen interest in public health in Wisconsin. It now represents more than 200 individual citizens as well as major health organizations and local health groups in the state. The State Medical Society is a charter member.

Main aim of the Health Council has been to examine specific health needs of Wisconsin, and encourage action by appropriate groups to make any needed changes and improvements. In the past few years, it has expanded its scope of interest into new fields, including health careers.

In this particular effort, it received the cooperation of the State Medical Society, Wisconsin Hospital Association, Wisconsin State Dental Society, Wisconsin Pharmaceutical Association, University of Wisconsin School of Pharmacy, Wisconsin Nurses Association and Wisconsin League for Nursing, in addition to many other groups which aided in gathering and compiling information for the brochure.

Alcoholism in Wisconsin 1959-1961

By R. D. NASHOLD, M. S. and HORST WADSACK, M. S.

Madison, Wisconsin

■ AN ESTIMATE of the magnitude of a problem for a given time and area is essential for the design of any sound program to deal with it. Unfortunately for the case of alcoholism, public attitudes—past and present, lay and professional[1]—have hindered direct methods of determining its prevalence and consequently programs for treating it. While hospital admissions,[2] records of social welfare agencies, arrests for drunkenness, and deaths due to alcoholism indicate certain areas of the problem, they cannot reveal the total situation. In some instances field surveys have been utilized, but the effectiveness of this method of data collection is limited not only by public attitudes toward the subject but also by the large expenditures necessary to conduct surveys of this nature. Because of the obstacles encountered in using direct methods for determining prevalence, attempts have been made to develop an estimation formula that uses cause of death data available from Vital Statistics registration systems.

At present the most successful method for indirectly estimating the number of alcoholics in a population was developed by Dr. E. M. Jellinek. This method has been critically evaluated[3-5] and was recently revised by Jellinek himself[6] after reviewing current survey and clinical data.

According to the revised Jellinek formula:

$$A = \frac{(D - D_n)\ 100 \times 1.22}{K} \times R$$

A = the total estimated number of alcoholics with and without complications living during a given year in a given area;
D = the number of reported deaths from cirrhosis of the liver during a given year in a given area;
D_n = the number of reported deaths from cirrhosis of the liver not attributable to alcoholism;
K = the percentage of all alcoholics with complications who die of cirrhosis of the liver;
R = the ratio of all alcoholics to those with complications;
1.22 = the comparability ratio for cirrhosis of the liver between the Sixth and Seventh revision of the International List of Causes of Death. The factors in this formula were developed for the Sixth revision while D is now on the basis of the Seventh revision.

The original Jellinek formula has been applied to Wisconsin data from 1949 through 1958.[7] The revised formula has been applied to data for these same years and also extended to the years 1959–1961 (Table 1). This revised formula indicates more alcoholics in Wisconsin than were previously shown. By using the original formula, Wisconsin was estimated to have approximately 100,000 alcoholics during 1955-1957, while application of the new formula to the same data would raise the estimate to 112,600. According to the new formula Wisconsin presently has almost 129,000 alcoholics. The current sex ratio is approximately 7 male alcoholics for every 1 female. While the state's adult population (age 20 and over) increased by about 6.3 per cent between 1950–1960, the number of alcoholics shows a spectacular 73.3 per cent increase—86.0 per cent for males and 23.6 per cent for females. These trend statistics should be interpreted very cautiously since even small changes in any of the constants of the Jellinek formula may significantly alter estimates of the prevalence of alcoholism.

Mortality From Alcoholism. The seriousness of the problem is further shown by the 446 known deaths attributable to chronic alcoholism over the three-year period 1959–1961. Table 2 strikingly shows the familiar pattern of shorter life span for those who have succumbed to alcoholism. The three-year summary shows that 54 per cent of the alcoholics die between age 40 and 59, whereas state mortality statistics show that only 15 per cent of the total population die in this age group. The median age of death for alcoholics is 55.2 years compared with 71.4 years for the entire population. In keeping with the progressive nature of alcoholism we find that the age-specific mortality rates increase until about age 70 then decline because of the effects of the major degenerative diseases.

Table 3 shows 50 per cent of those dying from alcohol were married at the time of

Mr. Nashold is Director, Statistical Services; and Mr. Wadsack is Statistician, Wisconsin State Board of Health.

TABLE 1—*Alcoholics in Wisconsin, 1949–1961, Number and Per Cent of Males and Females Aged 20 and Over*

3 year Periods	Male		Female		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
1949–1951	57,983	5.14	11,740	1.04	69,484	3.08
1951–1953	66,639	5.83	13,297	1.15	79,667	3.47
1953–1955	78,948	6.85	11,860	1.01	91,048	3.92
1955–1957	101,350	8.73	11,261	0.95	112,612	4.79
1957–1959	109,736	9.38	14,016	1.16	123,993	5.22
1959–1961	113,330	9.57	15,813	1.28	128,785	5.33
Per cent Increase in Proportion of Alcoholics 1950–1960		86.0%		23.6%		73.3%

The estimates were obtained by using the modified Jellinek formula as proposed by B. Brenner and E. M. Jellinek.

TABLE 2—*Resident Deaths Due to Alcoholism, by Age, Sex, Wisconsin 1959–1961*

Causes of Death with Mention of Alcoholism	I.C.D. Number	Total		Age Groups													
				Under 20		20–29		30–39		40–49		50–59		60–69		70+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Accidental Poisoning (Alcohol)	880	2								1		1					
Accidental Poisoning (Barbiturate)	871	2	1									1	1	1			
Alcoholic Psychoses	307	18	4					1	1	5		6		5	1	1	2
Acute Pancreatitis	587	4						1		1							
Alcoholism	322	78	20			2	1	7	2	20	7	25	4	14	6	10	
Cirrhosis of Liver (with Alcohol)	581	220	56			2		16	6	50	18	65	14	63	15	24	3
All others*		28	13			2	2	1	2	8	3	7	3	6	2	4	1
Total		352	94			6	3	26	11	87	28	105	22	89	24	39	6
Age-Specific Mortality Rates**		3.6				0.5		2.5		7.7		10.1		11.1		5.8	
Per Cent of Total		100.0				2.0		8.3		25.8		28.5		25.3		10.1	

*All others includes (12) from Excessive Cold (932); (16) from Other Diseases of the Liver (583); (8) Other Avitaminoses and Nutritional Deficiencies (286); (4) Suicides (971); (1) Epilepsy (353).

**Rates express per 100,000 population in each age group.

(Special notice should be paid to the fact that when "Laennec's cirrhosis" is given as the underlying cause of death by the attending physician on the death certificate, then the death is automatically coded to cirrhosis of liver with alcoholism according to the International Classification of Diseases categories.)

death. This does not vary significantly by sex. A larger percentage of males were either never married or divorced while a larger percentage of females were widowed.

Death from alcoholism occurs much more often in the urban areas of the state than in the rural. The three-year average rate for urban residents being 7.3 per 100,000 population aged 20 and over compared to the three-year average rural rate of 4.0 per 100,000 population aged 20 and over. When the Jellinek formula is applied to Milwaukee county, the result is an estimate of over 53,000 alcoholics. This is 41.5 per cent of all alcoholics in Wisconsin though Milwaukee county has only 25.8 per cent of Wisconsin's population.

TABLE 3—*Marital Status of Decedents From Chronic Alcoholism by Sex, Wisconsin, 1959–1961*

Marital Status	Total		Male		Female	
	Number	Per cent	Number	Per cent	Number	Per cent
Married	223	50.0	175	49.7	48	51.1
Never Married	73	16.4	69	19.6	4	4.3
Widowed	71	15.9	43	12.2	28	29.8
Divorced	75	16.8	62	17.6	13	13.8
Unknown	4	0.9	3	0.9	1	1.0
Total	446	100.0	352	100.0	94	100.0

Occupations listed on death certificates of those who die from alcoholism shows an under-representation of professionals, clerical and sales workers, farmers and operatives and an over-representation of laborers, service and private household workers (Table 4). This data is difficult to evaluate especially since loss of usual occupation is frequently part of the general social and economic deterioration associated with alcoholism. The data does suggest that occupations involving alcoholic beverages deserve special attention. The percentage of all alcoholic deaths represented by these occupations was 10.3 or 46 persons out of 446 deaths during the three-year period. Their specific titles were as follows:

Tavern owners or keepers	22
Bartenders and bar waitresses	15
Brewery Employees	8
Beer distributor	1
	46

TABLE 4—*Per Cent Distribution of Occupations for the Entire Labor Force and For Decedents From Alcoholism* by Sex, Wisconsin, 1960*

Occupation	Males		Females	
	Entire Labor Force	Decedents from Alcoholism*	Entire Labor Force	Decedents from Alcoholism*
Professional, Technical, and Kindred Workers	8.6	3.7	12.3	6.7
Farmers and Farm Managers	9.9	5.6	1.4	-
Managers, Officials, and Proprietors, Except Farm	8.8	13.3	3.0	2.2
Clerical and Kindred Workers	5.8	5.1	27.9	13.3
Sales Workers	6.1	4.2	8.7	-
Craftsmen, Foremen and Kindred Workers	19.4	19.3	1.3	4.5
Operatives and Kindred Workers	23.2	9.1	15.6	4.5
Private Household Workers	0.1	-	5.2	42.2
Service Workers, Except Private Household	4.9	7.4	15.9	24.4
Farm Laborers and Foremen	3.5	1.7	3.6	-
Laborers, except Farm and Mine	6.2	26.4	0.7	-
Not reported	3.5	4.2	4.4	2.2
	100.0	100.0	100.0	100.0

*The per cent distributions are based on data from death certificates for a three-year period, 1959–1961. An unknown number of retired persons are distributed according to their usual occupation while employed. Though housewives make up 52.1 per cent of the female decedents from alcoholism, they are excluded from the per cent distribution since they are excluded from labor force statistics.

As a final comment, by way of comparison, this study shows that 5.4 per cent of Wisconsin's adult population is alcoholic in contrast to an estimate of 4.5 per cent of the adult population of the entire country. This is more significant when it is noted that Wisconsin is one of the six states in the nation that lacks a state alcoholism program of any kind.

REFERENCES

1. Lipscomb, Wendal R.: Epidemiological methods in study of alcoholism, Amer. J. Pub. Health 49:327–333 (Mar) 1959.
2. Schmidt, Wolfgang and Smart, Reginald: Admissions of Alcoholics without psychosis to mental institutions, and estimated prevalence of alcoholism in Ontario, 1948–1955, Canad. J. Pub. Health 50:431–435 (Oct) 1959.
3. Seeley, J. R.: Estimating prevalence of alcoholism; critical analysis of Jellinek formula, Quart. J. Stud. Alc. 20:245–254 (Jun) 1959.
4. Brenner, B.: Estimating prevalence of alcoholism; toward modification of Jellinek formula, Quart. J. Stud. Alc. 20:255–260 (Jun) 1959.
5. Brenner, B.: Estimating prevalence of alcoholism from vital rates, Quart. J. Stud. Alc. 21:140–141 (Mar) 1960.
6. Jellinek, E. M.: Estimating prevalence of alcoholism; modified values in Jellinek formula and an alternative approach, Quart. J. Stud. Alc. 20:261–269 (Jun) 1959.
7. Stewart, William F.: Facts on alcoholism in Wisconsin 1957–1958, Wisconsin M. J. 58:661–662 (Nov) 1959.

TEACHING FILM ON CINE CORONARY ARTERIOGRAPHY

"Cine Coronary Arteriography," a teaching film which serves as an introduction to normal and abnormal coronary artery structure, has been issued by the American Heart Association.

Shown in the film are the following: selective catheterization of the left and right coronary arteries to visualize the human coronary artery tree; the wide range of normal anatomic variation in coronary artery distribution; and the response or normal vessels to nitroglycerine. The film also visualizes some of the many varieties of pathology which may develop in the human coronary artery system, and a few of the more frequently observed compensating patterns.

Medical authors of the film are Drs. F. Mason Sones, Earl K. Shirey, and Bernard V. Dryer, all of Cleveland.

Of particular interest to medical students, hospital house staffs and practicing physicians, "Cine Coronary Arteriography" is obtainable through sale or rental from the Wisconsin Heart Association, 205 West Highland Avenue, Milwaukee, of the American Heart Association.

PAMPHLET: Childhood Leukemia

"Childhood Leukemia—A Pamphlet for Parents" has been prepared for distribution by physicians to parents of leukemic children by the National Cancer Institute, Public Health Service, Department of Health, Education, and Welfare. It is available to physicians only, free of charge, from the Office of Information and Publications, National Cancer Institute, Bethesda 14, Md.

Termination of Resistant Tachycardia by Cardiac Countershock

By DAVID L. MORRIS, M. D., West Salem, Wisconsin

■ THIS CASE is presented because it illustrates the value of a new technique in converting a resistant, nearly fatal arrhythmia which had failed to respond to all conventional drug therapy. The author first became aware of the technique at the annual meeting of the State Medical Society of Wisconsin in Milwaukee during May 1962 when Dr. John Huston presented a discussion on the external cardiac defibrillator. In April 1962, Dr. Paul M. Zoll and Dr. Arthur J. Linenthal reported eight cases of arrhythmias in which external cardiac countershock was used to terminate tachycardias of several types.[1] The technique undoubtedly will become more widely used, and this case report should stimulate interest in the subject.

Case Report. A 56-year-old man was admitted to the hospital on July 7, 1962, complaining of severe chest pain and weakness. He had been seen at home where a short time before he had developed severe chest pain in the lower anterior chest and became weak, pale, and sweaty. He had been progressing satisfactorily after a posterior wall myocardial infarction in May 1962. His only medication was bishydroxycoumarin (Dicumarol). He was given morphine intravenously before his admission and was sent to the hospital by ambulance. His blood pressure at home was normal and his heart rate very rapid, approximately 180.

The initial electrocardiogram at the hospital showed a tachycardia with a rate of 180, probably of ventricular origin (Fig. 1). Quinidine was started orally, 200 mg. as a test dose, and later increased to 400 mg. every hour for 3 doses and then 400 mg. every 2 hours. There was no response to quinidine or carotid sinus massage, and on the evening of his admittance the blood pressure fell to below 90 systolic. At this time levarterenol was begun intravenously to maintain blood pressure at about 100 systolic.

The following day 1 Gm. of procaine amide hydrochloride was given intravenously in a period of 15 minutes with electrocardiographic monitoring. The rate slowed to 156 but the rhythm failed to convert to normal. Later the same afternoon 800 mg. of quinidine gluconate, diluted in 20 ml., was given intravenously. This also produced no change in the persistent tachycardia. This was repeated in a few hours when another 800 mg. of quinidine gluconate was given intravenously, still with no effect; and following this, 20 mEq. of potassium chloride in 500 ml. of 5% glucose in water was given slowly intravenously. That same

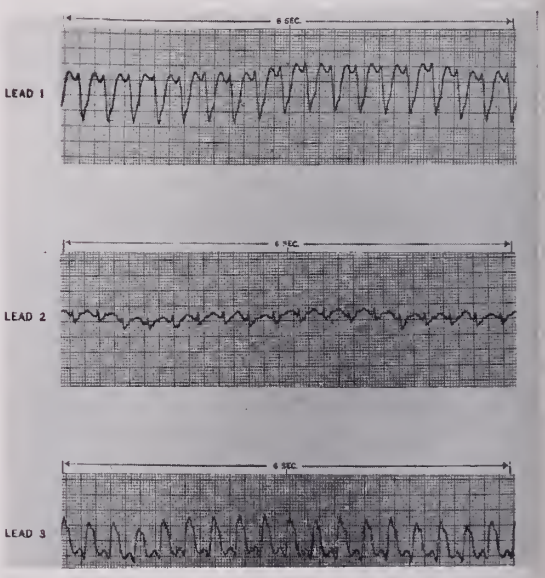

Fig. 1—This tracing is typical of the pattern which persisted for 12 days in spite of all medical therapy. It is thought to represent a ventricular tachycardia.

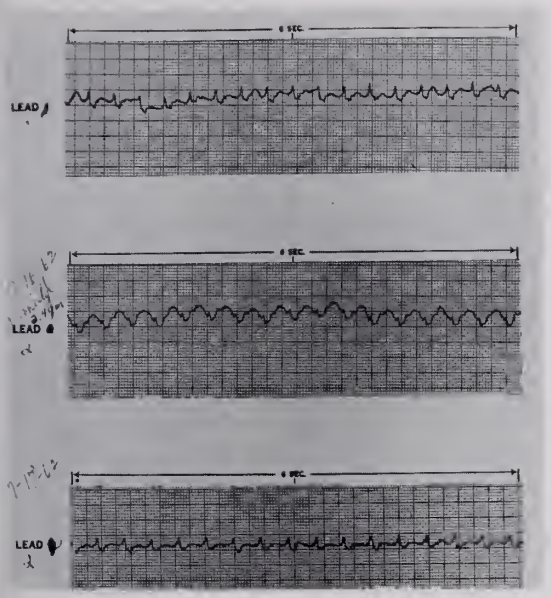

Fig. 2—These tracings show lead 2 on three different days (July 12, July 16, and July 17). The tracing of July 16 was taken after 2.4 Gm. of procaine amide hydrochloride had been given intravenously. The bizarre ventricular pattern is changed, but the rate slowed only slightly.

night procaine amide hydrochloride was continued orally with 1 Gm. every 6 hours.

The initial laboratory studies showed the white blood cell count elevated to 12,950. The prothrombin time was 41% and this was later maintained at 20 to 25%. Serum glutamic oxalopyruvic transaminase was normal at 27 units, two days after admission. Serum electrolytes and urine were normal.

Repeat electrocardiograms and persistent rapid rate suggested that we actually were dealing with a supraventricular tachycardia. Consequently, on the third day following admission 1.2 mg. of lanatoside C was given intravenously at once followed by 0.4 mg. three times within a period of six hours. The heart showed no response to the lanatoside C. Digoxin was started the next day at 0.5 mg. three times a day and continued five days before decreasing it to 0.5 mg. daily. The levarterenol was continued during this time to maintain blood pressure, and 200 mg. of diphenylhydantoin was also used every six hours orally for a period of 24 hours.

On the fourth day the blood pressure was maintained better and levarterenol was gradually discontinued. In the next several days digoxin was continued in a dose of 0.5 mg. three times a day. Procaine amide hydrochloride was given in a dose of 1 Gm. every six hours and quinidine was resumed on the seventh day following admission. The quinidine was given in a dose of 400 mg. five times daily (2.0 Gm. in 24 hours). This was continued on the sixth day to a top dose of 800 mg. every two hours for five doses and then 400 mg. every six hours. The quinidine slowed the heart rate to 160, but the tachycardia basically was unchanged.

On the tenth day, 4 Gm. of procaine amide hydrochloride was diluted in 250 ml. of 5% glucose in water and was given intravenously to a total dosage of 2.4 Gm. in a period of an hour with electrocardiographic monitoring. The basic rhythm was unchanged although the rate dropped to 150 (Fig. 2).

During the intravenous administration of procaine amide hydrochloride, it was necessary to give 5 to 10 mg. of methoxamine hydrochloride intravenously three times. When the procaine amide hydrochloride was discontinued, the blood pressure had fallen to 40/0 and the heart beat became inaudible. At this point further therapy with procaine amide hydrochloride intravenously was felt to be too hazardous and it was discontinued.

During the intervening days, from the tenth to the thirteenth, quinidine was continued at 400 mg. every four hours, procaine amide hydrochloride 1 Gm. every six hours, and digoxin 0.5 mg. daily. By the twelfth day the patient had become febrile, rales were present in the chest, the blood urea nitrogen rose to 56.4 mg. per 100 ml.; he was markedly confused, disoriented, and his condition was generally deteriorating.

On the thirteenth day the patient was subjected to cardiac countershock. This was done in the operating room with surgery set up for the possible use of direct cardiac massage or defibrillation. Under general anesthesia (thiopental sodium, nitrous oxide, and oxygen) with endotracheal intubation, the patient was attached to a cardiac monitor and cardiac pacemaker. While the patient was anesthetized, the blood pressure was approximately 100/80 and tachycardia persisted at a rate of 180 per minute. By means of two 8.5 cm. electrodes, one under the left clavicle and the other at the left lower costal margin below the apex of the heart, the patient was given 750 volts of 60 cycle alternating current from the Zoll electric defibrillator for 0.15 second. As soon as the cardiac monitor could be reconnected and as soon as

the pulse was felt after the shock, the rate was noted to be 80 and perfectly regular. The anesthetic was gradually discontinued over one-half hour with no alteration in cardiac rate or rhythm.

The patient was more responsive following the procedure. He was still quite confused for three or four days, but maintained a normal blood pressure and showed considerable general improvement. The rales in the chest cleared, the fever subsided, and the patient continued to be treated with 400 mg. of quinidine every four hours, 0.5 Gm. of procaine amide hydrochloride every eight hours, 0.5 mg. of digoxin daily, and was also given penicillin and streptomycin by injection. Further recovery over a week's time was rapid and the patient left the hospital one week later, 23 days following admission. He continued taking digoxin, quinidine, and bishydroxycoumarin at home.

The electrocardiogram immediately after the countershock showed old stigmata of the healed posterior wall infarction and myocardial ischemia with drug effect (Fig. 3). In the course of 5 days these changes of ischemia or drug effect improved. On July 28, 1962, the twenty-second day, the electrocardiogram showed only the old posterior wall infarction and digitalis effect. The patient continued to improve gradually, and his strength increased at home, so that two months following the cardiac countershock the patient was feeling fine.

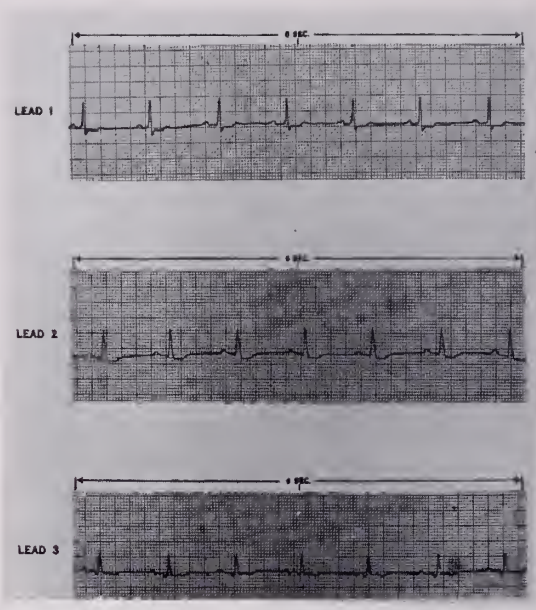

Fig. 3—This tracing was taken shortly after electric countershock was given on July 19, the thirteenth day. The rate is 68 and rhythm is of normal sinoatrial origin. It showed stigmata of a healed posterior wall infarction and myocardial ischemia or drug effect.

Comment. The technique and efficacy of closed chest cardiac countershock in treatment of ventricular fibrillation has been well documented.[2] It has more recently been found useful in treatment of resistant arrhythmias of supraventricular, nodal, and ventricular origin.[1,3,4,5,7] We thought we were dealing with a ventricular tachycardia, but in retrospect the stable heart rate over a period of many days with no change or deterioration in the form of the ventricular complexes do not support this. The majority of the cardiologists seeing the electrocardiograms agree on the impression of a supraventricular tachycardia with aberrant conduction. However, the exact etiology is unsettled.

The effectiveness of quinidine, procaine amide hydrochloride, and digitalis in the usual case of cardiac arrhythmia is well known. Levine reported quinidine given orally as effective in 46 of 57 cases of ventricular tachycardia, and Pascale reported 85 per cent of ventricular tachycardias converted by procaine amide hydrochloride by the intravenous route.[4] This patient received high or toxic levels of quinidine, procaine amide hydrochloride, and digitalis. It must be remembered that both quinidine and procaine amide hydrochloride can significantly depress myocardial contractility, and in the future cardiac countershock may well be proven safer and more effective than high doses of these medications.

The indications for cardiac countershock would include any type arrhythmia, especially in patients whose condition is desperate or in whom drug therapy is inadvisable or ineffective. The risks involved include the risk of a general anesthetic if the patient is conscious, and the risk of developing ventricular fibrillation or cardiac standstill.[1] The voltage used will depend upon the build of the patient. I think that the risk of ventricular fibrillation would be less if the voltage of the countershock were large enough to completely depolarize the cardiac musculature. Excessive current, however, will increase the duration of cardiac standstill.

The etiology of ectopic rhythms is controversial and not well understood. Theoreti-

cally, all the rapid arrhythmias can be considered as muscle cells, or groups of cells, acting out-of-phase with other cardiac cells. The duration of repolarization of heart muscle is very long, compared to skeletal muscle (150 or 200 millisec as compared to 2 or 3 millisec).[6] This longer duration of repolarization is protective against arrhythmias. Out-of-phase impulses reaching the cell while it is not completely repolarized will not depolarize the cell, and therefore will not be transmitted or cause the muscle cell to contract. Many factors including acetylcholine and reduced energy supply can shorten the duration of repolarization from 150 to as little as 10 millisec,[6] and this could allow out-of-phase contractions which would vary from extrasystoles, to tachycardia, to fibrillation.

If one considers this "asynchronous depolarization" as basic in the etiology of arrhythmias, it can then be seen why complete depolarization of the entire heart by means of controlled electric shock is so effective. Perhaps in the future the safety and efficacy of this technique will make it an important form of treatment of all cardiac arrhythmias and may, in fact, make it the treatment of choice early in the course of certain arrhythmias.

Summary. A case of persistent tachycardia to illustrate the importance of cardiac countershock in the treatment of resistant tachycardias is presented. The concept of asynchronous cardiac depolarization makes complete depolarization of the myocardium a theoretically sound treatment of various cardiac arrhythmias.

Addendum One. The patient was well until Oct. 5, 1962. While working outside, he noted a dull pressure and fluttering in his chest and weakness. On admission to the hospital he was found to have a ventricular rate of 180 and blood pressure of 120/98. He was given quinidine in dosages of 400, 600, 800, and 1000 mg. in a period of six hours. Twenty mEq. of potassium chloride was given intravenously with no effect.

Ten hours after admission his blood pressure dropped to 77/0 and he became cold and clammy. Levarterenol was started and the blood pressure was maintained at 90 to 100 systolic until anesthesia and surgery were prepared for cardiac countershock.

The heart remained at about 190; during anesthesia the blood pressure fell to 50 systolic. The levarterenol drip caused it to rise to 90 systolic, and cardiac countershock was applied as before at 750 volts. There was no effect on the heart after three shocks so the electrode positions were changed. The upper electrode was moved to the right of the sternum. On the second shock in this position the rhythm changed to a sinus rhythm with two rapid ventricular extrasystoles following each normal QRS complex. The blood pressure returned to normal. After a minute the ventricular extrasystoles dropped out, leaving a normal sinus rhythm of 60 per minute.

During the first week after countershock, the cardiac rate fell to as low as 44 during the night and a transient sinus block was noted. This disappeared as the patient became more active, and he was discharged feeling fine. He continued to receive 400 mg. of quinidine four times daily and 20 mg. of pentaerythritol four times daily.

Addendum Two. On Dec. 25, 1962, the patient developed a recurrence of the tachycardia while working in the cold. He was admitted to the hospital where he was subjected to countershock the same night. The rhythm converted after a single countershock of 750 volts with the electrode positions modified by our previous experience. The rhythm converted with one sinus beat followed by two rapid ventricular extrasystoles. After a minute (on ventilation with 100% oxygen) one of the ventricular beats dropped out, and in about another minute the other ventricular extrasystole dropped out, leaving a sinus rhythm at 70 per minute. He has continued to do well, but the maintenance of quinidine and procaine amide hydrochloride has been increased to 400 mg. of quinidine four times daily and 500 mg. of procaine amide hydrochloride four times daily.

Cardiac countershock, with synchronous depolarization of the heart is the physiologic approach to these arrhythmias. The persistent but gradual decline of out-of-phase ventricular activity on the last two countershocks would indicate that we had really been dealing with an unusually stable ventricular tachycardia. Esophageal leads would be helpful to prove this academic point.

Cardiac countershock has now been well established as treatment for resistant tachycardias and may well be the treatment of choice in ventricular tachycardia. The newer use of timed direct current countershock has definite advantages over the use of alternating current without timing. However, the equipment such as we used, and which is present in most general hospitals, offers an opportunity to save patients from a fatal arrhythmia with means already available.

134 North Leonard Street.

ACKNOWLEDGMENT: A special thanks to Doctors D. M. Buchman, W. B. Gallagher, B. E. Lloyd, and Robert Pribek for their help and encouragement.

REFERENCES

1. Zoll, P. M. and Linenthal, A. J.: Termination of refractory tachycardia by external countershock, Circulation 25:596–603 (Apr) 1962.
2. Zoll, P. M., Linenthal, A. J., and Zarsky, L. R.: Ventricular fibrillation; treatment and prevention by external electric currents, New England J. Med. 262:105–112 (Jan 21) 1960.
3. Zoll, P. M., Paul, M. H., Linenthal, A. J.: Effects of electric currents on heart, Circulation 14:745, 1956.
4. Alexander, S., Kleiger, R., and Lown, B.: Use of external electric countershock in treatment of ventricular tachycardia, J.A.M.A. 177:916–918 (Sept 30) 1961.
5. Milton, H. P. and Miller, R. A.: External electrical termination of supraventricular arrhythmias in congenital heart disease, Circulation 25:604–609 (Apr) 1962.
6. Burn, J. H.: Cause of fibrillation, Canad. Med. Assoc. J. 84:625–627 (Mar 25) 1961.
7. Crehan, J. P., Morris, J. N., and Kroeker, E. J.: Further application of electric countershock in ventricular tachycardia, J.A.M.A. 181:727–728 (Aug 25) 1962.

NONPOLIOVIRUSES AND PARALYTIC DISEASE

MAGOFFIN, ROBERT L. and LENNETTE, EDWIN H., *California Medicine*, 97:1 (July) 1962.

The authors review both their experience and the recent literature in cases clinically classified as "poliomyelitis." Where polioviruses could not be implicated other viruses were cultured and immunologic evidence of their presence was obtained.

In addition to the encephalomyelitic and meningitic complications of the common exanthemas of childhood, herpes simplex and mumps, all these viruses can cause predominantly spinal disease or simulate bulbar poliomyelitis by involving the cranial nerves and the respiratory center. The incidence of postinfectious encephalomyelitis following the common exanthemas of childhood is given as 1 in 700 cases of measles, 1 in 6,000 cases of rubella, and 1 in 6,000 to 10,000 cases of chickenpox.

The largest group of nonpolioviruses involved in paralytic disease are the enteroviruses (Coxsackie and ECHO). These viruses have been recovered from the blood and feces of patients as well as the nervous system of fatal cases. They also cause neuronal lesions in experimental infections of laboratory animals.

Whether they constitute etiologic agents or simply are coincidentally present is the question which the authors try to answer by a review of cases in California since 1956. Age affects the rate of recovery of both polioviruses and nonpolioviruses in paralytic cases being encountered more frequently in the younger age groups. Previous vaccination with Salk vaccine also decreases the recovery of polioviruses from paralytic cases, the rate being roughly inversely proportional to the number of immunizations received. Conversely the rate of recovery of nonpolioviruses rises. Finally, while in mild cases there seems to be little difference in the rate of recovery of polioviruses and nonpolioviruses, in severe cases polioviruses are more frequent.

If all cases where recovery of nonpolioviruses can be accomplished were taken into consideration, they might account for 10 per cent of cases of paralytic disease, predominantly mild. In summary, while there is evidence that viruses other than poliovirus can cause illnesses clinically simulating poliomyelitis, nonpolioviruses have not been demonstrated to be major contributors to the over-all occurrence of paralytic diseases in recent years.—*International Medical Digest*, 78:494 (Nov) 1962.

California State Department of Public Health, Berkeley, Calif.

UNITS TO TEST DIAGNOSTIC ABILITY AVAILABLE FOR PHYSICIANS' MEETINGS

Units that enable from 4 to 15 or more physicians simultaneously to test their ability to diagnose heart disease from case histories illustrated by x-rays and electrocardiograms are available on loan from the American Heart Association.

The units, prepared by the AHA Committee on Professional Education, have been designed in four-panel sections to accommodate large medical meetings and two-panel sections suitable for classroom use. Each self-illuminated section measures approximately 4 feet wide, 7 feet, 9 inches high, and 4 inches thick. Each panel illustrates a separate medical case with three x-rays and a set of electrocardiograms. Written case histories accompany the visual materials.

Groups wishing to arrange to use the units may write to the AHA Distribution Department, 44 East 23rd Street, New York 10, N.Y., for information on schedules and service charges.

Hyperglycemia and Chlorothiazide

By J. F. MARCH, M. D.
Algama, Wisconsin

■ CHLOROTHIAZIDE has been a remarkably effective drug in the control of congestive heart failure and hypertension. Toxic effects of this drug are not common. A few instances of hyperuricemia, hypokalemia, anaphylactic reactions, and skin eruptions have been seen. Another unfavorable response to the drug has attracted attention recently. This is the development of hyperglycemia. We have recorded 15 instances of patients who did develop hyperglycemia while under treatment with chlorothiazide.

Case Report. A 73-year-old male had been under my care seven years because of chronic coronary disease and congestive heart failure.

He was treated with a low-salt diet, weight reduction, digitalis, and successively with acetazolamide, chlormerodrin, and amisometradine. Chlorothiazide was started in March 1958. He was given from 250 mg. to 1,000 mg. per day according to his symptoms and the presence of rales in his chest.

Glycosuria 1+ first appeared in April 1960. On May 4, 1960, his glucose level was 191 mg. per 100 ml., and a diagnosis of diabetes mellitus was made. Treatment with tolbutamide in doses of from 1.0 to 1.5 Gm. per day brought his blood glucose levels to normal. His congestive failure was much easier to control. With reduction of the tolbutamide to 0.25 Gm. per day, fasting blood glucose determinations were in the normal range.

This patient is now able to work more than he did five years ago, has more vitality, and apparently more cardiac reserve.

Comment. This case has been presented in detail to show the development of hyperglycemia in a patient who had been treated with chlorothiazide for two years.

Cornish, et al.[1] studied the effects of chlorothiazide on the pancreas by treating 300 mice. They found that 7.1 per cent of the mice developed pancreatitis as evidenced by inflammation, edema, hemorrhage, and necrosis of acinar and interstitial pancreatic tissue. They also found that the amylase concentration increased 1.5 to 2 times the pretreatment levels in 50 per cent of patients taking full doses of chlorothiazide. The frequency of histologic lesions in mice increased directly with the duration of therapy. However, there were no abnormalities found in the islets of Langerhans.

Goldner[2] has investigated the effect of chlorothiazide on 20 diabetic patients and 20 nondiabetic patients by following their glucose tolerance curves. He found that 6 of 20 diabetics were made worse by chlorothiazide, whereas all 20 nondiabetics showed no effect on the glucose tolerance curve.

Goldner also showed that the thiazide effect on carbohydrate metabolism is not an interference with the agents used for the management of diabetes, since patients showed the same results whether they were on insulin or diet alone for the control of diabetes. The fact that hyperglycemia occurred in a minority of diabetic patients and not in any nondiabetic patients suggests a predisposition. Serum potassium levels did not change much in either group of patients. It is unlikely that thiazides are true diabetogenic agents.

Certain chemicals are known to produce diabetes: alloxan, quinolines, fluoroacetate, and some magnesium and chromate salts. One must consider the possibility of some chemical relationship between thiazides and one of these known chemical diabetogenic agents.

Shanklin[3] has shown acinar destruction in a 9½-year-old boy who had been treated with hydrochlorothiazide for 285 days.

Sugar[4] showed that acidosis can occur during pregnancy in two of his patients who were being treated with chlorothiazide.

It would appear that age is an important factor in this association. Hyperglycemia seldom develops in a young person being treated with chlorothiazide, but rather it seems to appear in some patients between the ages of 60 and 70 years and in many more who are over 70 years (9 of our 15 cases). The patients' diagnoses were all either arteriosclerotic heart disease or hyper-

tensive cardiovascular disease. Some individuals have a positive family history for diabetes mellitus (2 of our cases). It is interesting to postulate, therefore, that the pancreas is just worn out from too many years use and the beta cells are not producing a sufficient amount of insulin. If this is the case, then the number of patients developing hyperglycemia while being treated with chlorothiazide should parallel the number in a like age group who are not receiving the drug. However, this is not our clinical observation.

Insulin lack alone is not a factor apparently. Recent reports indicate adequate amounts of insulin in most people. However, in some individuals much of the insulin may be in a bound form and thus not available for action. Some persons are not able to break this bond to free insulin for usage. One can speculate that chlorothiazide has a stabilizing effect on the protein-insulin bond, or that it interferes with an enzyme system that should be breaking this bond.

There has seemed to be an association of time or duration of administration of chlorothiazide before hyperglycemia develops. It has been noted that more than 5 months duration of therapy was needed before we observed hyperglycemia, and the average duration of therapy was 21 months.

It has been noted that the individual prone to develop this is a debilitated person who has had an enlarged liver for a long period of time. Some are obese.

The total amount of chlorothiazide used does not seem to have a bearing on this problem. In other words, 0.5 Gm. in some patients produced diabetes whereas others were on 1.0 to 1.5 Gm. daily. However, Cornish[1] showed a relationship in dose and duration in his investigations.

Heart failure always noticeably improved when hyperglycemia was found and subsequently controlled during the course of congestive heart failure.

The diabetes that appeared was always easily controlled by an oral hypoglycemic agent or by insulin. In our series of 15 patients, 7 used tolbutamide, 2 phenformin, 1 chloropropamide, 4 insulin, and 1 watched diet alone. Therefore, one must consider whether the appearance of diabetes need necessarily be a valid reason to discontinue so effective a drug as chlorothiazide for control of edema.

Summary. The relationship between the administration of chlorothiazide and the development of hyperglycemia has been discussed. Fifteen cases have been observed and one has been presented in detail.

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REFERENCES

1. Cornish, Allen L., et al.: Effects of chlorothiazide on the pancreas, New England J. Med. 265: 673, 1961.
2. Goldner, M. G., et al.: Hyperglycemia and glycosuria due to thiazide derivatives administered in diabetes mellitus, New England J. Med. 262:403 (Feb 25) 1960.
3. Shanklin, D. R.: Pancreatic atrophy apparently secondary to hydrochlorothiazide, New England J. Med. 266:1097 (May 24) 1962.
4. Sugar, Samuel J. N.: Diabetic acidosis during chlorothiazide therapy, J.A.M.A. 175:618 (Feb 18) 1961.
Hollis, William C.: Aggravation of diabetes mellitus during treatment with chlorothiazide, J.A.M.A. 176: 917 (Jun 17) 1961.

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Physicians and medical students in the United States and abroad have an opportunity to further their education under notable authorities in the field of medicine through a series of professional teaching films, titled "Clinical Entities."

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Congenital Absence of the Gallbladder and Cystic Duct

By KENNETH A. SEIFERT, M. D., F. A. C. S.
Milwaukee, Wisconsin

■ CONGENITAL absence of the gallbladder and cystic duct in man is a rare anomaly. Tallmadge[1] of Marquette University, in 1938, reported 12 cases in a collected series of 18,350 autopsies, or an incidence of 0.065 per cent. One third of these cases were in children less than one year of age. Tallmadge stated, "a thorough search must be made for a gallbladder that is apparently absent, because the gallbladder may be shrunken, embedded in scar tissue, abnormally located, or enclosed within the liver. It should be remembered that agenesis of the gallbladder is an anomaly of the first order of rarity."

Dixon,[2] in 1945, reported 10 cases of congenital absence of the gallbladder which had been encountered at the Mayo Clinic prior to that time. The diagnosis was established by surgical exploration in these 10 cases.

In addition he collected 50 cases reported since 1900. In 26 of the 60 cases the anomaly was found at necropsy, and in the 34 remaining cases it was found at operation. In these 60 cases he noted jaundice in 48 per cent and common duct stones in 27 per cent. The average age of the patients was 46 years. He divided the 60 cases into three groups. One group consisted of infants where the absence of the gallbladder was noted at necropsy. The second group of cases was from infancy to 45 years of age, and the anomaly was usually found at necropsy. In the last group over 45 years of age, the diagnosis was usually made at surgery. He noted that 73 per cent of the cases over 45 years of age had symptoms similar to those found in cholecystic disease.

Latimer,[3] in 1947, collected 71 cases from the literature, 34 from surgical procedures and 38 from autopsies. He added 3 cases for a total of 74 cases. In 6 of the necropsy cases the cystic duct was present, so there were actually 68 cases of congenital absence of the gallbladder and cystic duct.

In 1961, Gerwig[4] reported 6 cases. He collected 55 cases from the literature from 1947 to 1961, including his own.

In 1962, McIlrath[5] reported 10 cases found on 26,531 routine necropsies at the Mayo Clinic.

If one adds the 55 cases of Gerwig, the 68 cases of Latimer, the 10 cases of Dixon, and the 10 cases of McIlrath, the reported cases to date total 143.

Reports of cases at Deaconess Hospital. At Deaconess Hospital in Milwaukee, there have been 5 cases of agenesis of the gallbladder and cystic duct recorded since 1956. Four of the cases will be discussed briefly and the fifth, my own case, will be discussed more extensively.

Case 1. A woman 22 years of age had had pain in the right upper quadrant for one week along with nausea and vomiting. There was no jaundice and the serum bilirubin was 0.95 mg. per 100 ml. The preoperative diagnosis was acute cholecystitis, or acute pancreatitis. At operation a large cyst of the lesser omental sac was found secondary to a massive saccular dilatation of the proximal common bile duct. No gallbladder or cystic duct was found. The cyst of the lesser omental sac was drained. The patient died on the twentieth postoperative day from pneumonia. An autopsy confirmed these findings.

Case 2. A 60-year-old woman had complained of vomiting for one month. X-ray studies showed a nonvisualized gallbladder. A preoperative diagnosis of chronic cholecystitis and cholelithiasis was made. At operation a duodenal obstruction secondary to an inflammatory mass was found. A posterior gastroenterostomy was done. No gall-

Presented at the fall meeting of the Wisconsin Surgical Society, Sept. 15, 1962, Madison.

bladder could be found. It was thought to be congenitally absent or severely contracted. The patient died 48 hours later from a pulmonary embolus. An autopsy showed an adenocarcinoma of the duodenum, with obstruction. The gallbladder could not be found. The autopsy diagnosis was absence of the gallbladder, either congenital or from inflammatory atrophy.

Case 3. A 46-year-old man had had attacks of pain in the right upper quadrant and flatulence intermittently for two years. X-ray studies showed a nonvisualized gallbladder. A preoperative diagnosis of chronic cholecystitis and cholelithiasis was made. At operation no gallbladder or cystic duct could be found. A normal common duct was isolated and aspirated. An intravenous cholangiogram was done which was unsatisfactory.

Case 4. A 57-year-old man had complained of bloating, gasseous feeling, and belching for four years. X-ray films showed the gallbladder to be nonvisualized. An intravenous cholangiogram showed the common duct to be normal with a 5 mm. diameter. A preoperative diagnosis of chronic cholecystitis and cholelithiasis was made. At operation no gallbladder was found. Exploration of the gallbladder region showed a remnant or strip of tissue which may have been the anlage for the gallbladder, but no gallbladder was found. The common duct was normal to palpation.

Case 5. My patient was a 30-year-old amputee. He was born with a deformed left leg which was amputated just below the knee at 7 years of age.

His present illness began suddenly the night before admission to the hospital on Nov. 29, 1961. He complained of severe pain in the right upper quadrant after eating pork chops. He had no nausea, vomiting, or diarrhea. There was no past history of intolerance to fatty foods. There was no history of jaundice.

Examination showed him to be a short, somewhat obese man. He showed definite tenderness over the gallbladder region with very little muscle spasm. There was no jaundice present.

His temperature was 99.2 F., pulse 92, and respirations 20. Urinalysis showed one plus albumin and 3,000 to 8,000 white blood cells per cu. mm. On admission blood chemistry studies showed a hemoglobin level of 13.6 gm. per 100 ml., hematocrit reading of 41%, 4,820,000 red blood cells, 6,800 white blood cells per cu. mm. with a differential count of 74 neutrophils, 16 lymphocytes, 8 monocytes, and 2 eosinophils. The day after admission his serum amylase was 95 units, the serum bilirubin was 0.9 mg. per 100 ml., and the prothrombin was 13 seconds, or 70%.

A preliminary x-ray film of the right upper quadrant was entirely negative. An oral cholecystogram showed no filling of the gallbladder. The cholecystogram was repeated with a double dose of the dye, and no opacification of the gallbladder could be demonstrated.

A preoperative diagnosis of acute cholecystitis was made. An exploratory laparotomy was performed on the third day after admission. The abdomen was entered through a right subcostal incision. The appendix was readily seen through the incision. The appendix was found to be the size of a man's little finger and bulbous at the apex with signs of acute inflammation.

There was malrotation of the large intestine present. An appendectomy was performed and a search was made for the gallbladder. Extensive examination failed to show the presence of a gallbladder or a cystic duct. There was no situs transversus present. The common duct was found to be more posterior than usual but normal in size throughout. No stones were palpable in the common duct. Numerous glands were felt at the point where the common duct entered the pancreas.

In view of the normal size of the common duct, the absence of palpable stones, the absence of jaundice, and because of the acute appendicitis, an operative cholangiogram was not done.

The postoperative course of the patient was uneventful. An intravenous cholangiogram was made on the third postoperative day. This resulted in opacification of the hepatic and common duct radicals. The common duct measured 4 mm. in diameter. There was passage of the opaque medium into the duodenum. No filling defects were seen within the common duct. A postoperative intravenous pyelogram showed horseshoe kidneys.

Daily urinalyses postoperatively were negative. The blood urea nitrogen was 10.4 mg. per 100 ml. A blood cell count on the fourth postoperative day showed 6,000 white blood cells per cu. mm., and a differential count of 73 neutrophils, 23 lymphocytes, 3 eosin-

ophils, and 1 basophil. The blood sedimentation rate was 45 mm.

The pathology report on the appendix was minimal periappendicitis. The patient has remained entirely asymptomatic since his surgery.

Comment. This fifth case is being presented as the 144th reported case of congenital absence of the gallbladder and cystic duct. Adding the other four cases reviewed would bring the total number of cases to 148. However, the more interesting aspect of this disorder is the associated abnormal physiology of the biliary system.

Dixon[2] has made some profound observations in these cases which are worth quoting. He states that there is often a marked discrepancy between the symptoms and findings in biliary surgery. He suggests that the symptoms of cholecystitis may frequently be a reflection of a process going on in the common bile duct or its sphincter rather than in the gallbladder. He noted that 58 per cent of reported cases of congenital absence of the gallbladder had jaundice and in 27 per cent stones were present in the common bile duct. Seventy–three per cent of patients over 45 years of age had symptoms. The high incidence of symptoms in the cases reported suggests the existence of some defect in the dynamics of the biliary tract. Critical evaluation of the situation reveals some similarity to the clinical picture of so-called postcholecystectomy syndrome. Dixon suggests that it is possible that the gallbladder acts as a pump reservoir and prevents a sudden fall of pressure in the biliary tract on opening of the sphincter of Oddi.

With the gallbladder absent it is possible that stasis of the contents of the biliary tract is greater than it is when the gallbladder is present. Congenital absence of the gallbladder is a distinct disadvantage. The clinical picture shows that disease of the biliary tract is more common in cases of congenital absence of the gallbladder than it is in cases in which the gallbladder is present.

Dixon reported that in 10 of 12 cases of congenital absence of the gallbladder in which the common duct was drained for a prolonged period complete relief of symptoms was obtained. On the basis of this evidence, Dixon advises prolonged drainage of the common bile duct by means of a T tube in cases of congenital absence of the gallbladder in which symptoms are present, even when the common bile duct is of normal size and stones are not found.

In 1959, Carnevali[6] stressed this same viewpoint. He reviewed the follow-up data on all cases of agenesis of the gallbladder reported to date. He found that those patients who underwent exploration and drainage of the common duct were subsequently asymptomatic. Those patients who did not undergo exploration or drainage of the common duct at the time of operation continued to have symptoms postoperatively.

The recent reports in the literature all stress that the diagnosis of agenesis of the gallbladder can be made only by means of an operative cholangiogram. Malmstrom[7] reported the first case proven by operative cholangiography in 1953. Carnevali[6] and Geraci[8] reported similar cases in 1959.

Summary. A case of congenital absence of the gallbladder and cystic duct is presented as the 144th reported case. The patient was a 30-year-old man, who in addition had an amputation of the left leg secondary to a congenitally deformed limb, horseshoe kidneys, and malrotation of the colon.

In addition four other cases of agenesis of the gallbladder and common duct from one hospital were reviewed. The implications of altered biliary tract physiology associated with congenital absence of the gallbladder were discussed.

It is deemed essential to do an operative cholangiogram in every case where a congenital absence of the gallbladder is encountered. If the patient is symptomatic, the T tube should be left in place for a prolonged period of time.

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REFERENCES

1. Tallmadge, G. K.: Congenital absence of gallbladder, Arch. Path. 26: 1060–1062 (Nov) 1938.
2. Dixon, C. F., and Lichtman, A. L.: Congenital absence of gallbladder, Surgery 17:11–21 (Jan) 1945.
3. Latimer, E. D; Mendez, F. L., Jr.; and Hage, W. J.: Congenital absence of gallbladder; report of 3 cases, Ann Surg 126:229–242 (Aug) 1947.
4. Gerwig, W. H., Jr.; Countryman, L. K.; and Gomez, A. C.: Congenital absence of gallbladder and cystic duct; report of 6 cases, Ann Surg 153:113–125 (Jan.) 1961.
5. McIlrath, D. C.; ReMine, W. H.; and Baggenstoss, A. H.: Congenital absence of the gallbladder and cystic duct: report of 10 cases, J.A.M.A. 180: 782–783 (June 2) 1962.
6. Carnevali, J. F., and Kunath, C. A.: Congenital absence of gallbladder, Arch Surg 78:440–445 (March) 1959.
7. Malmstrom, L.: Congenital absence of the gallbladder: report of a case diagnosed at operative cholangiography, Acta chir. scandinav. 105:440, 1953.
8. Geraci, C. L.: Congenital absence of gallbladder; diagnosis by operative cholangiography, Arch Surg 78:437–439 (Mar) 1959.

CLINICOPATHOLOGIC CONFERENCE

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Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: JOSEPH M. LUBITZ, M. D.

Milwaukee, Wisconsin

Case Presentation.* This 61-year-old housewife was hospitalized in June 1958, because of persistent jaundice, pruritus, a 30-pound weight loss and dark urine, which had begun eight months previously. Her stools were brown. Just prior to the onset of jaundice, she had been hospitalized in October 1957 for evaluation of epigastric distress and belching. Gastrointestinal series, barium enema, and gallbladder x-ray studies were negative. While in the hospital, she became very agitated, distrustful, and manifested extreme fear of having cancer. Two of her sisters had died of malignancies.

She was transferred to a mental hospital where she was placed on chlorpromazine (Thorazine). She was released while still taking this medication two weeks later, improved mentally, but slightly jaundiced. Icterus increased, and in December 1957 she was again hospitalized. Repeat gastrointestinal x-ray studies were negative. December 1957 laboratory studies were as follows: hemoglobin level 12.6 Gm. per 100 ml., hematocrit reading 44%, white blood cell count 6,100 per cu. mm. with a normal differential. Urinalysis showed one plus albumin, two plus sugar, 15 to 20 white blood cells per high-power field. Total serum bilirubin was 54.0 mg. per 100 ml.; direct was 35.0 mg. per 100 ml. Thymol turbidity was 3.4 units, prothrombin time 41%, icterus index 120 units, alkaline phosphatase 8.6 units, cephalin flocculation one plus, urinary urobilinogen 2.4 mg. in 24 hours, serum amylase 6 units, fasting blood sugar 136 mg. per 100 ml. She was discharged without improvement. The jaundice persisted and increased, and in June 1958 she was readmitted.

On physical examination the patient was poorly nourished and markedly icteric. Blood pressure was 130/80 and pulse 96. A Grade 2 apical systolic murmur was heard. The liver was palpable 2 cm. below the right costal margin. Rectal examination was not remarkable. Laboratory studies showed a hemoglobin level of 13.3 Gm. per 100 ml., hematocrit reading 40%, white blood cell count 11,700 per cu. mm. with a normal differential. Urine had one plus bile. Twenty-four hour urinary urobilinogen was 5 mg. Prothrombin time was 29.6%, cholesterol 2,170 mg. per 100 ml., thymol turbidity 3.0 units. Total protein was 6.1 gm. per 100 ml. (albumin 4.05 and globulin 2.05). Zinc sulfate turbidity was 2.2 units and alkaline phosphatase 76 units. A chest x-ray film was reported as negative.

The patient was treated with bed rest, vitamin K, dehydrocholic acid (Decholin), meprobamate (Equanil), and her pruritus was controlled with colloid (Aveeno) baths. She developed ankle edema which was treated with chlorothiazide (Diuril). A needle biopsy of the liver showed plugging of bile canaliculi. The hepatic cells were well preserved and centrally located cells contained bile pigment deposits. The biopsy diagnosis was biliary stasis. In spite of treatment, the jaundice persisted and the patient left the hospital. She sought consultation in another city where the diagnosis was confirmed. She was then put into a home for nursing care. She died 9 months later—17 months after the jaundice began.

Pathological Discussion. *Dr. J. M. Lubitz:* We have changed the usual format of the clinicopathologic conference in revealing the final diagnosis to Doctor Lindert at the beginning of the discussion. As physicians, you are treating patients with chlorpromazine and undoubtedly are having a problem of jaundice developing. I would like to present the autopsy findings and then discuss in greater detail the problem of chlorpromazine-induced jaundice.

At autopsy this patient was extremely emaciated weighing only 95 lbs. Her skin was an intense yellow-green color and her

* From St. Francis Hospital, Milwaukee.

sclerae were extremely jaundiced. On the back of her shoulders were decubitus ulcers. In the chest there was some spongy edematous lung tissue, with atelectasis in the posterior portions of the lower lobes. Microscopically this showed hypostasis. In addition there were nodules of aspiration bronchopneumonia in both lungs. The heart showed nothing significant. The myocardium was soft, flabby, and yellow-green in color. The coronary arteries showed nothing remarkable. In the abdominal cavity there were two liters of yellow fluid. The liver weighed about 1,800 gm., not appreciably enlarged. It was flabby and not increased in consistency. The capsule showed some wrinkling, with a very fine granularity, and on section there was a complete loss of the usual architecture, with an indistinct green appearance. The gallbladder was collapsed. The hepatic ducts were completely patent. In fact, the hepatic duct itself was slightly dilated to 6 mm. in diameter. Careful examination was made of the biliary tree for any evidence of obstruction and none was found. The spleen weighed 350 gm., twice normal size. It was somewhat flabby. The kidneys were enlarged and green. They showed the picture which is designated as cholemic nephrosis. The urinary bladder and the gastrointestinal tract showed nothing abnormal. The pancreas showed a slight degree of chronic pancreatitis.

The original needle biopsy showed the characterized features of early biliary obstruction which is seen in chlorpromazine intoxication. The portal areas may show a slight inflammatory reaction, but in this case it was remarkably little. The problem in a case of jaundice is to determine the type of obstruction. Was this an intrahepatic obstruction, a medical problem, or was this one of extrahepatic bile duct obstruction which would become a surgical problem? In this case, there was no evidence of any alteration, stagnation, or inflammation in the portal areas or of the larger bile ducts, so we considered this as an intrahepatic biliary stasis entirely compatible with chlorpromazine intoxication.

Figure 1 shows the section of the liver which was found on autopsy examination, it is not normal liver. The cord cells are broken up into small degenerating clusters, separated by delicate bands of fibrous tissue. This is a picture that is not ordinarily seen in the common form of cirrhosis. In portal cirrhosis, there is fibrosis in portal areas, with

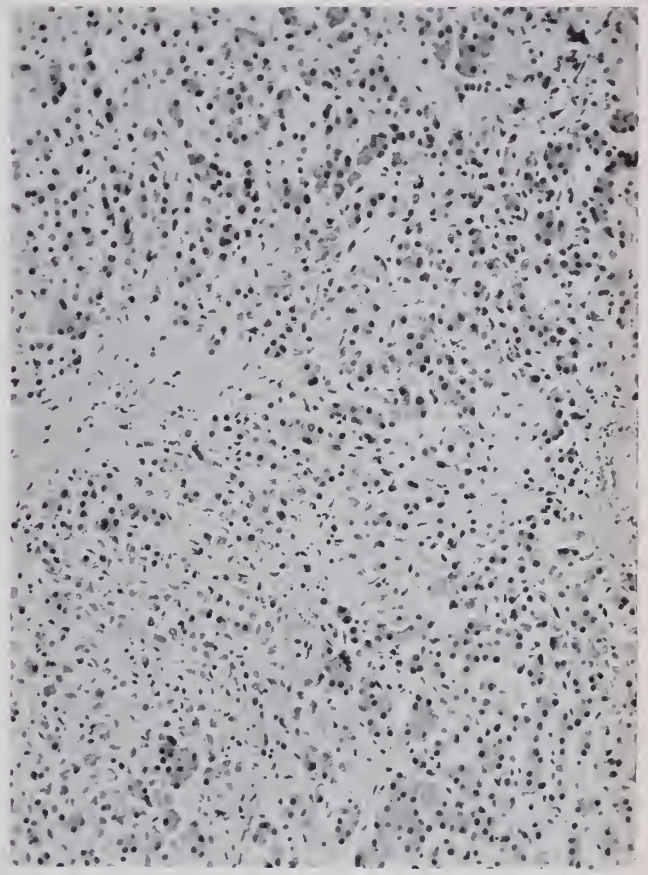


Fig. 1—(Low power) Liver: The entire liver shows an increase of fibrous tissue, in the portal areas as well as in the lobules, between individual card cells. These liver cells in many areas are atrophic or degenerated.

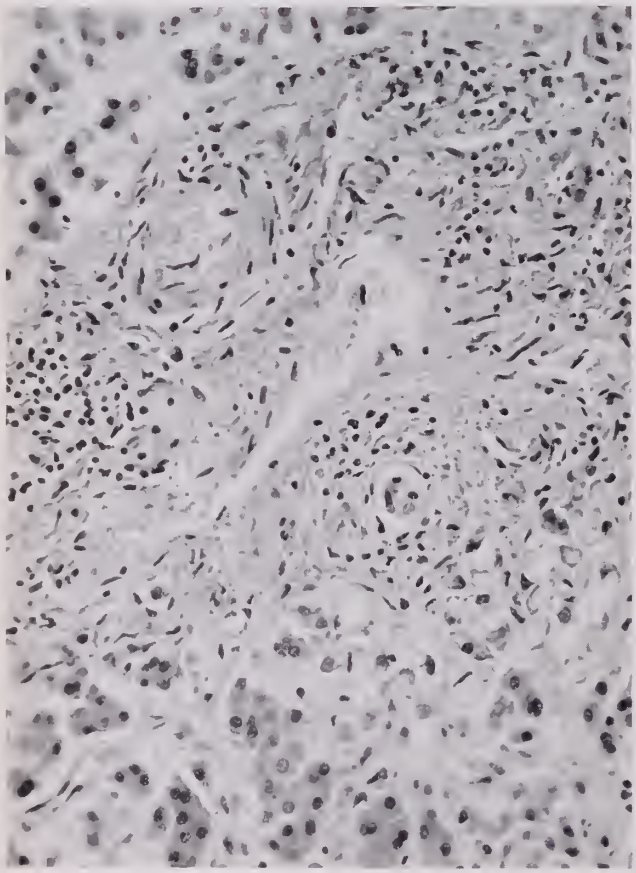
some strands extending out into the parenchyma, not in the delicate diffuse intracellular pattern as seen in Figure 1. In biliary cirrhosis one would expect to find dilatation of the bile ducts, with inflammation. In our case the ducts are not dilated, and there is not much acute inflammation around the bile ducts. On high power (Fig. 2), there are seen denser bands of fibrous tissue in the portal areas extending between the cord cells and separating them. There are atrophic liver cells and cells that look like giant cells, perhaps regenerating liver tissue. Some of the cells contain bile pigment. The Kupffer cells also are pigmented.

Figure 3 shows a reticulum stain to bring out reticulum, which is the precursor, or is present in fibrous tissue, and shows the considerable increase not only in large masses, but even between the cells. Usually a single band of reticulum is seen surrounding each

cell, but in Figure 3 there are duplication and fragmentation.

This is classified as primary biliary cirrhosis as opposed to the secondary, or extrahepatic obstructive, type. It is a rare form of biliary cirrhosis, a type of intrahepatic obstruction. Pathologically we are unable to adequately explain the mechanism of obstruction. It has been postulated by investigators working in this area that there is an obstruction at the site where the small bile ducts meet the larger bile ducts at the portal areas. This is presumably the site where fibrosis begins, so that there is in essence obstruction of the smaller bile ducts. I am unable to ascertain whether this assumption is correct. In this case we have a rather diffuse type of fibrosis, and I would hesitate to say that there was obstruction at any one particular area.

Fig. 2—(High power) Liver, portal area: Fibrous tissue in the portal area is increased and extends into the lobules, separating individual card cells. Presumably it is at this site where the smaller bile ducts which drain the lobules enter the larger bile ducts that abstruction occurs.



Biopsy of the liver indicated typical chlorpromazine intoxication, showing biliary stasis. As far as we know, no case has been described resulting in cirrhosis and death. However, similar cases due to arsphenamine and other drugs have been studied with a similar clinical and pathologic course.

Clinical Discussion. *Dr. M. C. F. Lindert* (internist) : This is an extremely significant case to present. To Doctor Lubitz' and my knowledge, up to this time no one has reported a case of biliary cirrhosis occurring secondarily to any form of drug-induced cholestatic hepatic disease. The term cholestatic disease has been applied in preference to the term chlorpromazine hepatitis, since it is felt that the mechanism is that of an intrahepatic cholestasis. Why this occurs is unexplained at the present time. Perhaps within a few years, with the assistance of the electronic microscopy studies, additional information may be obtained in this particular type of case.

One patient whom we have followed at a veterans hospital is in the third year of low-grade jaundice and is progressing to a picture of an early cirrhosis. Dr. Sheila Sherlock of London has under observation a patient who is now about three years in duration with chronic jaundice following the administration of chlorpromazine. However, when one reviews the literature on cholestatic jaundice, practically all authors state that this is a situation which will occur, but that it does not injure the liver cells particularly, and that the patient invariably will recover. Therefore, there has not been much attention directed to this occurrence as far as producing a chronic form of liver disease is concerned.

Relative to the mechanism other than cholestasis, Doctor Lubitz touched on the fact that it is believed to occur at the site of the so-called cholangioles or at the juncture of the interlobular canaliculi with the portal bile duct system. C. Watson originally postulated that these people may have an increased permeability of the cellular structure in this area and have a leakage phenomenon. Others postulated that this was perhaps an allergic reaction. Some cases will demonstrate evidences of early peripheral blood eosinophilia. Sometimes liver tissue for biopsies in the early stages of chlorpromazine jaundice may reveal an eosinophilia in the liver substance. In this case, this was not demonstrated in

the liver biopsy and certainly was not demonstrable in the advanced state of the cirrhotic change.

I would like to discuss the case presented a little further, and then make some comments about *primary* biliary cirrhosis. There are two things that are rather interesting to me. One is that the patient did develop very high blood cholesterol toward the end with 2,170 mg. per 100 ml. of total cholesterol; it is curious that coincident with this very high blood lipid finding the *thymol turbidity* remained normal. Invariably one may find a false elevation of thymol turbidity in the presence of very high blood lipids. It is also interesting to note that in the early phases of this intrahepatic obstructive jaundice the patient had a rather minimal elevation of alkaline phosphatase, the initial figure in December 1957 being 8.6 units, whereas later it rose to 76 units. Therapeutically these people finally become tremendous medical problems, and I think that Doctor Collins, who has managed this patient, likewise realizes this. I will go into this aspect of the problem when I discuss the general features of primary biliary cirrhosis.

We speak of primary biliary cirrhosis in differentiating from the more common form of biliary cirrhosis, that occurring secondary to extrahepatic biliary obstruction due either to stones, stricture, carcinoma, or the like. Although primary biliary cirrhosis is a rare condition, we are perhaps going to see more cases of primary biliary cirrhosis of the intrahepatic type. It has been suggested that the designation of primary biliary cirrhosis be dropped and that the term of chronic intrahepatic obstructive jaundice be adopted. There is no particular advantage to this other than to classify patients who for months or years do not have the classical anatomical picture of cirrhosis (as proven by either biopsy or autopsy in those who happen to have died of some other illness), but who do present a pathologic picture compatible with an intrahepatic obstructive disease. The descriptive terminology is rather unwieldy, but we will find this term creeping into the literature more and more. The etiology of biliary cirrhosis is extremely obscure.

The clinical picture of a patient with primary biliary cirrhosis is quite different than that of ordinary Laennec's cirrhosis, which is so common to all of us. Usually the onset is very insidious. Many times these patients are erroneously managed, particularly because the earliest symptom may be that of disturbing itching. Concomitant with this unexplained itching, there may be a peculiar unrelenting type of malaise and progressive easy fatigability, and sometimes these people are erroneously classified as being psychoneurotic or psychotic. At times these patients manifest the earliest phase of their illness by tanning unusually easy. Progressive hepatomegaly is a feature of this disease, but very large livers are seldom seen. Most of the patients I have seen have had just two to four fingerbreadth hepatomegaly. Rarely, if ever, a tender edge is noted, as one sees in acute hepatitis or in the patient who has cirrhosis and may have a sudden enlargement of the liver. In contrast, the liver remains persistently enlarged, firm, sharp-edged, and usually not tender. A great percentage (80 to 85%) of these will have splenomegaly, and a number may go on to develop a picture

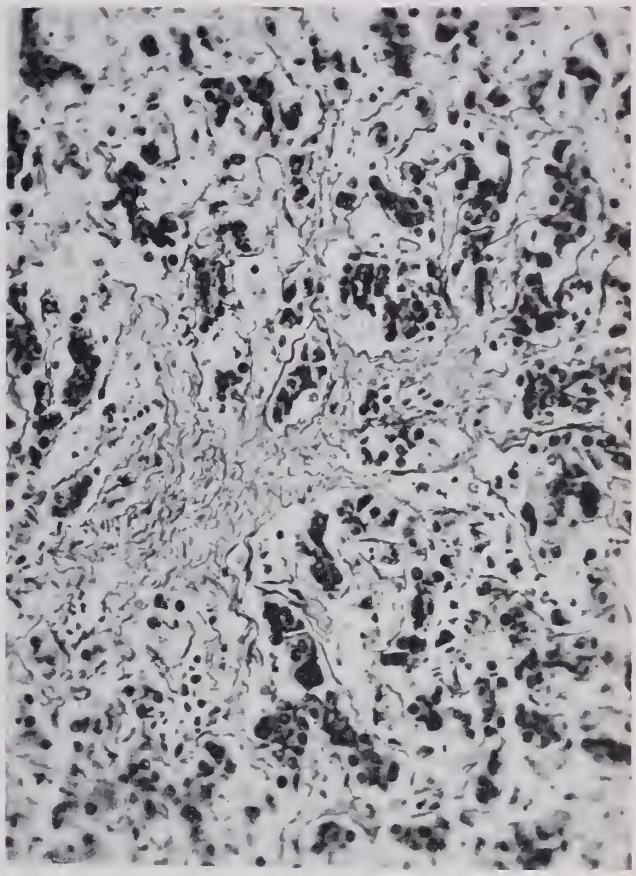


Fig. 3—(High power) Liver, portal area: Reticulum stain. The dark bands represent reticulum fibers forming connective tissue, extending between individual cord cells.

of portal hypertension, with esophageal varices and complications. Generally, their course is entirely afebrile. Finally, it is very uncommon for these people to develop a typical picture of ascites, edema, or anasarca. Very occasionally, in the preterminal phase, a patient may accumulate some fluid in the abdomen. Doctor Lubitz, did this patient have any ascites?

Doctor Lubitz: Two thousand ml.

Doctor Lindert: How long was that in existence?

Dr. E. G. Collins (attending physician): Only a very short time.

Doctor Lindert: That is usually the clinical course. These people do not develop an ascites, even though they have other features of portal hypertension. Invariably there is an absence of abdominal pain. There may be vague discomfort, bloating, belching or gas, but abdominal pain is not a feature. Curiously enough, all during the course of the disease of primary biliary cirrhosis, these patients will have variably colored stools. Urine, of course, will reveal darkening. As time goes on, the patients become more and more deeply jaundiced, their skin becomes more deeply pigmented, and they develop very aggravating pruritus. Because they have very little bile getting into the intestinal tract, there is a very marked calcium deficiency. They begin to utilize their own calcium and develop osteomalacia, then sustain spontaneous fractures, particularly of the vertebrae. From the biochemical standpoint, these are the things that we encounter. The serum bilirubin is elevated; sometimes it is minimally so. They may have a one-minute serum bilirubin of 1.5 to a total of 2.5 mg. per 100 ml.—just enough elevation to account for their pruritus, but not enough elevation to even make them clinically icteric. Most of the serum bilirubin during the course of the disease is prompt reacting, or the type which we see with an obstructive jaundice. Invariably they will eventually have elevation of the alkaline phosphatase. Usually, the alkaline phosphatase rises and persists at very high levels. We are not positive why people with extrahepatic obstructive jaundice or intrahepatic obstructive jaundice have elevations of alkaline phosphatase. It has been quite definitely shown that it is not purely on a basis of mechanical obstruction. Some have postulated that possibly there is a stimulation of the biliary epithelium to produce more alkaline phosphatase, and this irritative stimulation pours out more and more alkaline phosphatase.

Many patients will develop elevated blood cholesterol at times in the range of 1,000 to 3,000 mg. per 100 ml. With the prolonged elevation of blood cholesterol, they may develop skin deposits, and we may see typical xanthoma tuberosa. The other enzyme studies, the transaminases, have not been particularly altered. Some of them will have minimal or mild elevations of the serum glutamic oxalacetic transaminase or serum glutamic pyruvic transaminase, but not into the levels that one sees in patients having hepatocellular necrosis. Even in this patient who died in the terminal cirrhotic phase, the serum proteins and the albumin globulin ratio remained near normal. That is not the type of thing seen in a typical Laennec's cirrhosis. If one has the facilities to do electrophoretic pattern studies, it is cited that one may detect minor alterations of the alpha-2 globulin and the gamma globulin. The turbidity studies are helpful in this regard: (1) the thymol can be falsely positive, and (2) the zinc turbidity or the cephalin-cholesterol flocculation and other turbidity tests invariably are normal, indicating that the hepatocellular function is not disturbed.

Prothrombin time may become prolonged; and as the disease progresses with the development of secondary cirrhosis, the patient ultimately will develop prothrombin deficiency. As the jaundice increases, the amount of bile in the urine will increase and the amount of urinary urobilinogen will increase. In this patient, you will note that on initial study, the quantitative urinary urobilinogen in a 24-hour period was perfectly normal, anything up to 4 mg. being normal. She had 2.4 mg. per 100 ml. during a 24-hour period in December 1957; but then when studied again later had 5 mg., which was just above the normal range, indicating that there was progressive liver damage.

As far as differential diagnosis with primary biliary cirrhosis is concerned, the most obvious one to all of us is that from extrahepatic biliary obstruction, which sometimes is extremely difficult. Sometimes patients are erroneously diagnosed as having primary biliary cirrhosis when they actually have a secondary biliary cirrhosis. At times, patients have been explored; the extrahepatic

ductal systems carefully studied; pancreas, duodenum and sphincter examined, and no abnormalities were found. Ultimately, when the patient succumbs, the disease is found higher in the major biliary radicles, principally in one of the main hepatic ducts. Obviously, if one is in doubt with this type of case, the patient should be explored and the biliary ductal system should be carefully investigated, and concomitantly surgical cholangiography should be done in an attempt to visualize the main hepatic duct radicles. Unless that is done, one cannot be sure that the biliary stasis described in the liver biopsy slide may not be on the basis of an extrahepatic biliary obstruction.

Treatment is entirely symptomatic. The most difficult part of the treatment is the management of the intense pruritus. These people have relief of their pruritus if given methyltestosterone, or norethandrolone (Nilevar). They have very little benefit from any of the antihistamines and all the other substances. When methyltestosterone is used, as I have in desperation in a couple of patients, the jaundice becomes much, much deeper, but it does not alleviate the course of the disease one iota. These patients will develop very marked calcium loss, and supplemental calcium should be given. Most of the patients that I have seen have had spontaneous fractures, particularly of the vertebrae.

The psychic problem these people have is quite marked, and it is very difficult to keep them happy. With the itching, with progressive downhill course, with constant jaundice, with progressive deep pigmentation of the skin and with the multiple fractures, these people are really miserable patients to have and to take care of. Fortunately, as Doctor Lubitz mentioned earlier, these are very, very rare. In a recent review by Dr. Sheila Sherlock, from her London experience over a 15-year period, she had collected a group of approximately 42 cases. In 13 to 14 years, I have seen about a dozen of these that have fit into the picture of primary biliary cirrhosis, and they are extremely difficult problems.

Doctor Collins attended this patient, and he had considerable difficulty. Here was a woman who was getting deeper and deeper jaundice, everything pointed to obstruction, and still he had the courage to advise against surgical intervention.

Doctor Collins: There is nothing to add except that I reacted as anyone else would. I told the patient to stop taking the chlorpromazine and the condition would clear up. She would come in periodically for inspection, but it did not clear up. I decided to hospitalize her to see how much damage had been done. She had hope and asked me about surgery. I told her that I did not think surgery would help her, but that we would watch her, and if anything developed, perhaps then it would be advisable. She had a surgeon in mind in another city. We followed this jaundice for about a year. She had pruritus and we used dehydrocholic acid and tripelennamine (Pyribenzamine) for the itching. She seemed to get along well, but on her last admission, when she began scratching holes in her skin, I prescribed trimeprazine (Temaril) which is related to chlorpromazine chemically. I deferred using it, but the itching became so intense that I ordered it anyhow, and it seemed to help. After this episode, she still had hope. She had heard of people who had had jaundice for years and got well. Her sister took her to another city to see a surgeon. He thought it better not to explore her. During all this time, there were no masses felt in her abdomen. The liver was not tender, and there was no pain. I consoled her with the fact that there was nothing occurring there except for the reaction to the medicine. It was strange that her fear of cancer, which started the whole thing, never returned to her. I also considered cancer of the pancreas, but I watched her and was never able to palpate anything. She had severe hemorrhages of the nose, vagina, and subcutaneously, and she died.

Doctor Lubitz: Doctor Lindert, you remember we had several previous cases of intrahepatic obstruction. You suggested that there might come a time when it would be advisable to explore the bile ducts. Even though nothing is found, some of these patients do better after a simple exploration and probably tubing of the ducts. How do you feel about that now?

Doctor Lindert: That has been attempted by others, and everyone becomes desperate in these situations and tries to think of something that can be done to help these people. We have done that on a number of patients at the veterans hospital, and have kept a T-tube draining for as long as possible, usually up to a year at a time, and possibly we have benefited some of them. I am

continued on page 270

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

Pharmacology "A Justification"

By HAROLD F. HARDMAN, M. D., Ph. D.
Milwaukee, Wisconsin

■ THE FORMAL study of Pharmacology was introduced into American Medical Schools in 1891 at the University of Michigan. So began the science of how chemical molecules alter living substance, marking the beginning of the end of Materia Medica in this country. The science grew slowly spreading from Michigan to Johns Hopkins in 1893, to Western Reserve in 1898, and to Wisconsin in 1908. This young science developed in an unfriendly environment because its predecessor, Materia Medica, had done little to justify its position in the medical curriculum. Oliver Wendell Holmes had stated in his inimitable way, "If the whole Materia Medica (excepting only opium and ether), as now used, could be sunk to the bottom of the sea, it would be all the better for mankind,—and all the worse for the fishes." Only a hardy subject could be expected to survive in such a scathing climate. Survive it has; growth, reproduction and adaptation have also improved the product and now its future is secure with exciting promises of new developments. The new developments are not limited to fields of laboratory and clinical research. They extend into the areas of teaching, scholarship, and the training of medical scientists.

Can instruction in a basic science subject like Pharmacology be an exciting experience for a medical student? Of course it can. Some of you remember Loevenhart, Tatum, and Beckman. They are examples of the right combination of man, personality, and subject who have helped to shape your comprehension of drug therapy. We cannot offer our students better men today, but we can offer them an improved subject which has matured. New methods of instruction and testing are also available and they are characterized by greater flexibility with some degree of tailoring to the individual student. Most of you remember the rigid systems of rote memory, the nearly incomprehensible body of knowledge organized in bizarre patterns of botanical origin, clinical use, or chemical structure. Much of this has changed because we teachers can now offer you a more rational interpretation of drug action based upon an improved knowledge of physiology, chemistry, and physics. The biological sciences have recognized and adopted the concepts of statistics. Our awareness of variability and the errors of measurement have provided a sophistication which makes us better scientists and better physicians. The interpretation of the effects of drugs upon our patients need not be limited to symptomatic improvement, for we can now measure objective criteria accurately to support our therapy in the form of clinical chemistry and physiological function such as cardiac output, blood flow, and electrical activity of muscle or nerve. In some ways we tend to be more dogmatic and with justification. Thus the art becomes easier as we support our decisions with objective scientific information. Perfection seems unattainable; however, our rate of progress is impressive to the most pessimistic bystander. Our teaching is still imperfect but our explanations come closer to the ultimate truth as our comprehension and measurement of human physiological and pathological function continue to improve.

As a teacher of the subject of modern Pharmacology, I try to impress upon my students their need for the fundamental concepts of this subject. Regardless of the field of medicine, all physicians make use of for-

eign chemical molecules in the diagnosis or treatment of disease. The use of drugs in therapy requires your critical evaluation of the patient's response within a framework of pharmacological principles. In this regard it is akin to the stereotyped procedure of taking a history and performing a physical examination. Remember to consider these points in your next therapeutic adventure:

(1) Make use of single chemical agents whenever possible. A mixture of drugs creates a complex situation that usually defies interpretation. The drug houses supply mixtures only because you demand them. They are in business to please you and therefore are responsive to your requests.

(2) Recall the dose-response relationship concept. Vary the dose to achieve a desired effect or stop when undesirable effects outweigh the therapeutic response. Many patients and drugs are abused by the physician who adheres to a fixed dose schedule of one tablet, then two or three without regard for the milligram increment in dosage involved in each additional tablet. Too often the patient receives too little or too much drug on the basis of a single tablet.

(3) Look beyond the target organ for signs of drug response. Early toxic reactions to the drug may occur in remote areas of the body. No drug affects only one target organ in the body. Review the secondary sites of action of your drugs before your attention becomes fixed upon the usual primary site of action.

(4) Finally, accept the concept that molecular modification can alter biological activity in many desirable ways. Look to unbiased sources for information on this subject.

One of the new developments in academic pharmacology is the renewed interest in therapeutics with the formation of courses in clinical pharmacology. These courses should be taught by pharmacologists in cooperation with the clinical faculty. Too often our present day medical students receive their instruction in therapy from residents who lack long experience and formal training in this subject. This is an important reason why we graduate physicians who cannot evaluate the promotional literature of the pharmaceutical companies. There is great confusion in this area, and it is my hope that our medical schools will meet the challenge by providing better instruction in how to treat the disease once the diagnosis has been made. There is no less satisfaction in the effective treatment of a patient than is obtained in the most sophisticated diagnosis. It is only the combination of these two factors that defines good medical care.

I have spoken of the pharmacologist as a teacher of medical students, offering courses in fundamental principles to the sophomore student as well as integrating physiological and biochemical concepts through the explanation of how drug molecules alter normal and abnormal function. Following an introductory course, the ideal program offers further training in clinical pharmacology to the senior medical student and interested house staff in the form of therapeutic ward rounds and clinical conferences. In addition to teaching medical students, a program of instruction for graduate students is also an important function of the pharmacologist. Such programs provide personnel trained in the methods and evaluation of experimental investigation. It is also the major source of future teachers of the subject. I would like to see more graduate M.D. students return for this special training and follow a career in medical basic sciences. They need not divorce themselves from patient contact within the framework of a department which offers both laboratory and clinical programs in the subject. There are hopeful signs that other basic science faculty members are showing a renewed interest in clinical problems. This has developed primarily because the clinical faculty has entered the area of basic research and realized the value of special training in experimental design, statistical evaluation of data, and controlled experimental conditions. As our areas of common interest expand and our training programs overlap, we can expect better cooperation and more meaningful results in our common problems. This approach can provide answers to problems rather than the plethora of disconnected research reports that now glut our journals and seem so unintelligible to most of us.

Research occupies about 50 per cent of our total effort as medical school faculty members, assuming an average teaching load. It is a very important part of our existence, for it provides an outlet for our common curiosity concerning life processes. We pursue the problems of our choice because we enjoy the work and at the same time consider that our efforts may ultimately benefit mankind. This work is calculated to provide answers to

specific questions and here the individual scientist becomes an artist. His skill is communicated to others of his kind and the conclusions reached may provide instant or delayed benefits to you and your patients. This part of our lives requires protection and at the same time generous support. We have had both privileges in recent years because of a generous Congress and inspiring leadership at the National Institutes of Health. I doubt that major changes will occur in this area of support to threaten our freedom or support. The NIH has gradually evolved a progressively more flexible approach to research support. Initially NIH supported only project research which gave promise of answers for problems of immediate concern. Gradually it has begun to support men for indefinite periods of time. This is certainly a greater risk but offers admirable features which remove some of the objections to project support, such as the pressure for frequent publication to justify renewal of the research grant. One may even speculate that eventually NIH will provide research funds to support faculty positions per se because research personnel are becoming a national and international necessity and their perpetuation must be guaranteed.

The life of the teacher-researcher is still a good life, rich with satisfaction. With improved facilities, more knowledge of our subjects, a reasonable increase in our material rewards, and more diversity in our total endeavors we offer better instruction to all who seek our help. We hope that you will exert your influence upon our young people to encourage the most capable and talented of our students to consider careers in academic medicine. We need the best to serve as teachers of the science and art of medicine and to function as the scholars who will illuminate and set guideposts in the vast body of medical knowledge. In this way those who follow the profession of medicine may walk with less temerity than the original explorers as a result of better instruction and inspiring leadership.

CLINICOPATHOLOGIC CONFERENCE

continued from page 267

not convinced, however, that there is enough evidence of benefit. Furthermore, I have no logical reason as to why they should derive benefit by having persistent drainage of the extrahepatic ductal system. Everyone else who has tried it in the past has abandoned it. I do think, however, that it is extremely courageous not to explore these people; because if I were in a similar situation, I would have the patient explored. There is nothing about the clinical picture, the laboratory studies, or other factors that can make you state positively that this is primary intrahepatic and not possibly extrahepatic, so I think the patient does deserve the benefit of the exploration. I have seen patients who have developed jaundice and were erroneously thought to have chlorpromazine jaundice, only to have a common duct stone or carcinoma of the pancreas.

Dr. T. J. Pendergast: There have been isolated reports that prolonged cortisone therapy has been helpful to these people.

Doctor Lindert: Negative. Corticosteroids, in the last report of Doctor Sherlock, seemed to be of no benefit to these people with primary biliary cirrhosis.

CYTOLOGY DEMONSTRATION SLIDES

The cytology department of the State Laboratory of Hygiene has assembled a library of demonstration slides. These slides are available for study to all pathologists and cytologists in the state. The sets of slides available are in the following categories: vaginal and cervical—26 boxes; respiratory—12 boxes; GI tract—6 boxes; GU system—11 boxes; breast—3 boxes; spinal fluid—1 box; exudates—3 boxes; miscellaneous—2 boxes; and filters—1 box.

These demonstration sets include 25 slides each. All examples are from cases in which the diagnosis has been confirmed by tissue biopsy. The slides are numbered and are accompanied by a master list which gives the final diagnosis in each case.

The State Laboratory will loan two sets of slides at a time; the laboratory receiving the slides may keep them for two weeks after which they should be returned. Any particular sets may be requested, or if desired, the whole series may be borrowed, in which case two additional boxes will be sent when the previous slides are returned.—State Laboratory of Hygiene *Newsletter*, January 1963.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

JUNE 1963
Vol. 62 No. 6

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Somehow Labor Speaks

■ NORMALLY, the comments of the labor press on the subject of tax supported medicine—or anything else for that matter—scarcely merit the notice of citizens seriously interested in the problem of providing adequate medical care for our nation. But as an example of irresponsible, muddle-headed, rabble-rousing demagoguery, the editorial page of the May 9th issue ought to be memorialized.

The editorial writer asserts the novel doctrine that the cost of medicare would "simply be a transfer of what is now

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Editorial reprinted from the *Labor Press*, May 9, 1963

Hill Goes Over the Hill

Dr. N. A. Hill, president of the state medical society of Wisconsin, last week hit a new high in ridiculous statements on medicare.

Hill said that the King-Anderson bill would cost the state an astronomical sum in added taxes.

What he didn't say is that this money raised through social security would be used to pay doctor and hospital bills for all who need it.

The money would simply be a transfer of what is now being paid by individual patients to $50,000 a year physicians to the government having some control over payments to the medical profession—by far the highest paid and lushest living group in the country.

Somehow we'd rather have the government determine what a fair fee is for medical service or an operation rather than the profit hungry doctor.

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being paid by individual patients to $50,000 a year physicians to the government having some control over payments to the medical profession—*by far the highest paid and lushest living group in the country.*" (Italics ours, syntax of the labor press).

Obviously whoever wrote this dilly hasn't the foggiest notion of what a physician receives in a year from his practice, and he isn't too interested in finding out even though the statistics are readily available. And where he gets his critique of plush living must remain a mystery. If he thinks we $50,000 plutocrats live it up, he ought to see what goes

on at the Americana and the Balmoral in Miami Beach when labor's moguls hold their annual conclave. And that would be just a starter.

To top off his ejaculation of venomous hostility, the labor press's editorial writer concludes that "Somehow we'd rather have the government determine what a fair fee is for medical service or an operation rather than the profit hungry doctor." *Somehow* we would rather have the government stay out of the business of regulating prices for goods and services. Most Americans, right and left, labor and capital, still believe there are areas in our lives in which the government has no proper function. But the labor press *somehow* (italics ours again) would rather have the government regulate somebody else.

What, we wonder, would the labor press have to say if the government regulated what a carpenter could charge? What if the government told plumbers they had to barrel out in the night every time a drain backed up, and what he could then charge for those services? What if the government enjoined auto mechanics, television repairmen and electricians from charging more than a sane, reasonable amount? How would the labor press feel about the shoe pinching its own foot?

Government regulation, such as the silly editorial suggests for the medical profession, is, when extended, nothing less than a characteristic of the corporate state. Italy tried it and it was called Fascism. In Germany it was called Naziism. In Russia, this same kind of regulation is a concomitant of Communism. Is this what the labor press has in mind—somehow?—D.N.G.

Distaff Dialectics

A way to help convey organized medicine's point of view more effectively to the general public has been suggested by statistics recently released by the Association of American Medical Colleges.

Medical College Admission Test data, reports the Association, show that the verbal ability of women applicants to medical schools is relatively higher than that of male applicants. The Association's report indicates that men do better in quantitative and scientific skills than do women. "This basic profile. . . . has previously been demonstrated for the male and female population in general," says the Association.

If our patients don't understand us or our point of view, we have clearly failed to communicate with them. It's no secret that as a profession doctors have prosaic public relations. The concept many lay persons have of the medical profession is distorted, exaggerated and far removed from reality. Perhaps we have been too busy practicing our profession to make sure that our patients know who we are and what we are.

Although more women have entered medical schools in recent years, the actual number of female medical school graduates remains at about 5% of the total. This compares with 12% in Canada and 24% in Great Britain. No indication is given in the release of the Association as to why women drop out, particularly after they have earned their bachelor's degree, a relatively constant 35% of all those granted. It is certainly worth an investigation to learn what, if anything, can be done to keep women in medical school until they graduate and join the ranks of the medical profession.

Aside from purely esthetic considerations, the presence of a larger number of women doctors may substantially improve our communication with the public and relieve us strong, silent type doctors to the exercise of our statistically higher quantitative and scientific skills. Our public concept will assuredly improve pari passu an improvement in the physician shortage. Let us do all we can to encourage women to enter the medical profession.—D.N.G.

Physicians Evaluate Little League Baseball

EDITOR'S NOTE: The desirability of athletic competition for children is the concern of parents, schools, recreation agencies and other youth-serving organizations as well as that of the public in general. As part of its continuing research program, Little League has initiated and has in progress several studies on the effect of competitive athletics upon young boys. Recently a group of 1,331 physicians participated in a study on the effect of Little League baseball on their sons who were participants in the sport. The medical evaluations, based on intimate contact and practical experience, were compiled by the Research Division of Little League Baseball, which has its headquarters at Williamsport, Pennsylvania. They are presented in this analysis as a service towards better understanding of competitive athletics and their effect on children.

THERE ARE several significant findings reflected in the consensus report of physicians whose sons have participated in Little League Baseball.

Generally, this cross section of medical men who reported their opinions found Little League to be an activity well adapted to the emotional, physical and social capacities of the average boy in the 8–12 year old age groupings.

Doctors do not always agree that activities in which their sons participate are appropriate as evidenced by their attitude toward tackle football. Fifty-six per cent indicated their sons played competitive football but only 15% agreed that tackle football was a satisfactory sport for boys of this age group.

Specifically, the sample of physicians noted agreement that:

1. Little League Baseball is an appropriate activity for the age, maturity, skill, stage of growth and physical make-up of boys 8–12 years of age.
2. Participation in Little League has a favorable effect on emotional and social adjustments during the growing-up period. Emotional reaction does not contribute to abnormal psychological response and does not affect digestion, assimilation or elimination.
3. Boys play to win, but often are losers. Neither the competitive drive to win nor the experience of losing produce undesirable responses in boys of Little League age.
4. Physical exertion required to play Little League Baseball is well within the capacity of the 8–12 year old boy. There is no evidence that participation taxes the heart, lungs or kidneys, nor does it carry players beyond the stage of healthful fatigue.
5. Fractures at the growth center of the immature long bones (epiphysis) are not common. Dislocations which might cause permanent disability are rare.
6. Little League does not require too much time. Boys thoroughly enjoy the experience.
7. Tournament play makes more physical and emotional demands than normal league play but is not detrimental to health or well-being.
8. There is no evidence that boys develop excessive aggressiveness or acquire a false set of values as the result of Little League Baseball.
9. Little League is not over-commercialized on the local level.
10. Where over-emphasis occurs, parents and over-zealous managers are usually responsible.
11. Baseball is the most popular sport with boys in the Little League age bracket, followed in order by basketball, football, swimming and track.
12. Children who participate in competitive athletics are more physically fit, more relaxed and confident, have better poise than children whose athletic activities are not competitive.

COMMENTS FROM THE PRESS

BETTER TO KNOW THAN WONDER

The medical profession seems to be putting increasing stress on public education toward prevention of disease and early discovery of symptoms that could lead to serious trouble.

The anti-polio campaign in Racine County, seeking not only to protect possible victims but to eliminate "carriers," is an example on the preventative side.

The continuing drive against cancer is partly preventative. By early recognition of symptoms, medical science has a much better chance of curing, or at least retarding, the disease.

Along somewhat the same line is the plan, announced this week by the Racine County Medical Society, to conduct a large scale diabetes detection survey next spring. Purpose of this will be to give people an opportunity to learn whether they have diabetic tendencies. Early diagnosis often averts the full disastrous effects of this malady which was fatal to 650 Wisconsin persons last year.

When he learned about this campaign to come, a Racine resident said, half jokingly: "What are they trying to do—worry us to death by planting ideas of what may be wrong with us?" But of course it's better to know than to wonder. The more who learn in time about such things as diabetes, the lower the death toll from it will be. And the fact that education of the public along such lines is increasing, helps greatly to explain why the life span of Americans has been steadily lengthening.—Reprinted from the *Racine Journal-Times*, Nov. 16, 1962.

Minutes of Annual Council Meeting

Madison, February 23–24, 1963

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 7:45 p. m. on Saturday, February 23, 1963, at Society headquarters in Madison following conclusion of the Wisconsin Work Week of Health and the Annual Conference of County Society Officers.

All councilors were present except Doctors Chojnacki and Hollenbeck, Doctor Frank being present Saturday only. Officers and others present were President Hill, Sunday only; President-elect Egan; Speaker Callan; Vice Speaker Carey; AMA Delegates Simenstad and Quisling, and Saturday only, Bernhart and Galasinski; Stovall, Saturday only. Staff and consultants: Messrs. Crownhart, Thayer, Ragatz, Toser, Hansen, Waldschmidt, Idzik, Sumnicht (Saturday); Robert Murphy and John White; Mmes. Ruth May and Jean Anderson; Miss Pyre. Present for special orders on Sunday were Drs. John Evrard, Keith Keane, Edward Houfek, Charles Wunsch, and T. J. Nereim. F. J. L. Blasingame, M. D., Executive Vice President of the AMA, was present for a time Saturday evening.

2. Approval of Minutes

On motion of Doctors James-Curran, carried, minutes of the November 1962 meeting were approved as distributed.

3. Election of Officers

On separate motion duly made, seconded and carried, the following were unanimously reelected for one-year terms:

A. Chairman of the Council: James C. Fox, M. D., La Crosse

B. Vice Chairman of the Council: John M. Bell, M. D., Marinette

C. Treasurer of the Society: F. L. Weston, M. D., Madison

D. Assistant Treasurers: H. Kent Tenney, M. D.; John T. Sprague, M. D., and E. J. Nordby, M. D., all of Madison

E. Secretary of the Society and of the Council: C. H. Crownhart, Madison

F. Editorial Director of the *Wisconsin Medical Journal:* D. N. Goldstein, M. D., Kenosha

4. Councilor District Reports

In compliance with Chapter VI, Section 2 of the Bylaws, each councilor was called on and made "an annual report of his work, and of the condition of the profession of each county in his district."

5. Conflict of Interest

The secretary reported, in compliance with the Statement of Policy on Conflict of Interest adopted in 1962, that all major employees and all councilors and officers had duly executed the statement as required by the Insurance Commissioner, and no conflicts have been reported.

6. Immediate Reactions to Wisconsin Work Week of Health

Various councilors and officers who had participated in the week's programs, and Doctor Blasingame, expressed favorable opinions. The secretary asked that the Council approve planning for a repeat of the event in 1964 to allow the maximum period of time to arrange it even more effectively in light of the first experience.

On motion of Doctors Nordby-Dessloch, carried, a 1964 Wisconsin Work Week of Health was approved, and the staff was commended for the work done on the 1963 conference.

Doctor Willson asked that consideration be given to making the program somewhat self-sustaining.

7. Legislation—Executive Committee Report

A. Blood Insurance

The Council reviewed minutes of the Committee on Clinical Medicine with respect to two bills proposed by the Milwaukee Blood Center, 68, S. and 69, S.

Following discussion, Chairman Fox stated the position of the Council as favoring 68, S. which would establish blood transfusions as services rather than the sale of a product, and take them out of the area of implied warranty as used in the sale of goods. It would protect blood centers and hospitals from liability except for negligence.

As for 69, S., which would prohibit the sale of insurance against the cost of human blood for transfusion purposes, with certain exceptions, the Council took no position on the legislation as such, noting it had previously endorsed a resolution of the Milwaukee Blood Center on the need for voluntary contributions of blood and opposition to blood insurance.

B. Kerr–Mills

Proposed text of legislation to implement the Kerr–Mills Act in Wisconsin was presented to the Council and discussed by Mr. Murphy. This had been drafted by attorneys for the Wisconsin Hospital Association, the Wisconsin Pharmaceutical Association and the State Medical Society, and the Wisconsin Nursing Association and State Dental Society had also shown interest in it. Mr. Murphy reported that the current draft had been submitted to Mr. Tiffany, who advised against WPS participation should the proposal as written be adopted without modification to make insurance an optional provision.

Discussion followed, which was summarized by the secretary as indicating that the State Medical Society is in favor of implementing Kerr–Mills legislation in Wisconsin; it does not stand committed to any exclusive manner of implementation; it does stand committed to any feasible way of doing it in a practical, effective manner; insurance is not necessarily the only way; it could be done under contract such as with the Department of Defense for the care of dependents of the military; and that as matters develop in the Legislature on this subject, basic policy

will be cleared with the Council through its Executive Committee, and to the extent feasible with the Commission on Public Policy.

The Council took no formal action on the proposed draft; but on motion of Doctors Dessloch-Kief, carried, reaffirmed its support in principle of Kerr–Mills implementation.

C. Basic Science Amendments; Ad Hoc Committee

The Executive Committee recommended support of a bill to add biochemistry, bacteriology and hygiene as subjects for examination. It reported that there was disagreement among parties interested in the legislation as to retention or deletion of physical diagnosis, and recommended that if the bill were introduced without the latter, it be restored by way of an amendment. The Commission on Public Policy recommended the same position.

The Commission on Public Policy had recommended appointment of ad hoc committees to meet with the Board of Basic Science Examiners, with the State Board of Medical Examiners, and with state officials on various legislative or enforcement matters.

The Executive Committee recommended appointment of one committee composed of Drs. E. J. Nordby, J. H. Houghton, and the president and president-elect.

On motion of Doctors Blanchard-James, carried, these recommendations were approved.

D. Radiation Control

The Executive Committee reported for information that it had reviewed in January and approved a bill which would require registration of all radiation devices by the end of the year, with the Industrial Commission and the State Board of Health in joint jurisdiction of implementation.

E. Chiropractic

Also reported for information was a meeting with the Executive Committee in January by Drs. E. J. Nordby and Herman Wirka regarding an appearance they would make with Doctor Hill before the Industrial Commission's Advisory Committee on Workmen's Compensation, at the latter's invitation, in rebuttal to legislation proposed by chiropractic to allow treatment of Workmen's Compensation cases.

F. Vital Statistics Law

The current status of a bill to revise the Vital Statistics Law, as proposed by an advisory committee to the State Board of Health, was not clear.

On motion of Doctor Nordby, seconded and carried, the subject was referred to the Commission on Public Policy.

G. Hospital Licensing Law

There was as yet no bill to report to the Council for its instructions.

H. Proposed Legislation—Deferred

The Executive Committee reported its review of legislative proposals relating to (1) confidentiality of health research records and reports; (2) the practice of podiatry; and (3) cancer quackery. Action was deferred on making any recommendations to the Council for the present, it being considered that their introduction was untimely.

I. Blue Cross Bill 131, A.

The Executive Committee of the Commission on Medical Care Plans, meeting February 22, 1963, reported as follows:

"The analysis of Bill 131, A. as originally introduced appears beyond any question to permit the hospitals, through their collection agency, Blue Cross, to enter into the field of the practice of medicine in various ways; and for these and other reasons it believes that the bill in its present form deserves the active and effective opposition of the State Medical Society and recommends that the manner, method and mechanisms be handled by the Council through its Executive Committee and/or the Executive Committee of the Commission with the understanding that the Council and Commission will be kept fully informed as time goes along."

On motion of Doctors Nordby-J. H. Houghton, carried, the recommendation of the Executive Committee of the Commission was approved, Doctor Willson abstaining.

The Council recessed at 10:05 p. m. and reconvened at 9:25 a. m. on Sunday, February 24.

8. L. O. Simenstad, M. D.

Doctor Bell reported that the Wisconsin AMA delegation had decided to put Doctor Simenstad's name in nomination for a vacancy on the board of trustees of the AMA at the June 1963 meeting.

On motion of Doctors Bell-Dessloch, carried, the Council gave its unqualified support to Doctor Simenstad.

9. Statement on Osteopathy

On motion of Doctors Dessloch–Nordby, carried, the following statement, proposed by the Planning Committee, was adopted:

"Voluntary professional relationships between a Doctor of Medicine and a Doctor of Osteopathy should not be deemed unethical if the county medical society determines that the Doctor of Osteopathy:

"(1) Is currently licensed to practice medicine and surgery under the Medical Practice Act of the State of Wisconsin.

"(2) Practices the healing art founded on the broad and all-inclusive principles of scientific medicine.

"(3) Submits himself and any hospital with which associated, if proprietary, to the same voluntary surveillance common to those hospitals which adhere to the principles of the Joint Commission on Accreditation of Hospitals.

"(4) Does not possess, in addition to his degree of Doctor of Osteopathy and Surgery, the degree of Doctor of Medicine obtained solely by the transfer of credits and not by resident enrollment in an approved medical school.

"(5) Comports himself according to the Principles of Medical Ethics as those Principles have been and will be applied or interpreted from time to time.

"The State Medical Society of Wisconsin, by and with the consent and advice of county medical societies, will encourage such doctors of osteopathy as meet these standards to attend appropriate programs of postgraduate education, and will meet with representatives of the Wisconsin Association of Osteopathic Physicians and Surgeons on matters of mutual interest from time to time."

10. Wisconsin Osteopathic Association

John Evrard, M.D., reported a proposal which had come from an osteopathic physician that the State Medical Society present a program on maternal mortality at the forthcoming convention of the Wisconsin Osteopathic Association.

On motion of Doctors Blanchard–Nordby, carried, the Council authorized the Commission on State Departments, through its Division on Maternal and Child Welfare, to explore and conduct such training and review of maternal problems with the osteopaths as it deems fit and proper.

11. Status of Management Survey

The Executive Committee reported that at its regular meeting on December 1, 1962, it had invited a meeting with the special survey committee on December 8 to determine the status of the study by Booz, Allen and Hamilton. At that meeting it was concluded to arrange another meeting for presentation of a progress report by the committee and consulting firm. This was held on January 19, 1963, and after presentation and discussion of the incomplete report by representatives of Booz, Allen and Hamilton, with no recommendations being disclosed, the committee took the following actions:

A. That the secretary of the State Medical Society and a representative of the Medical Society of Milwaukee County be authorized to confer with the special committee on the management survey and with the firm of Booz, Allen and Hamilton on the full proposed report, such conferences to cover the scope and accuracy of the portion of the report pertaining respectively to each organization.

B. That the report from Booz, Allen and Hamilton, through the special committee, be submitted to the Council at the earliest practical date.

The secretary stated that the report had not as yet been received from Booz, Allen and Hamilton.

In discussion, several reasons for the Council's interest in the report were pointed out, among them being that the House resolution called for a progress report to the Council, and the Council had earlier taken the protective action that when completed, the report be delivered to management, copyrighted, and referred to independent legal counsel for review to make certain that it contained no defamatory or other material harmful to any party or organization which might be mentioned in it.

No further action was taken by the Council.

12. Future Council Meetings

The Executive Committee reported its belief that holding two Council meetings in recent years in connection with the North Central Conference had served the purpose of acquainting councilors and officers with that organization and with officers of member state societies, and recommended that meetings in that location be terminated for the present. It recommended further, after discussing the possibilities of meeting in LaCrosse in July, that the Council hold its summer meeting instead at Society offices in Madison.

On motion of Doctor Willson, seconded and carried, the recommendations were approved.

13. Voluntary Certification of Groups Ancillary to Medicine

On motion of Doctors Dessloch–Nordby, carried, the following statement was adopted by the Council:

"The tremendous development of medical sciences over the course of the last several decades in particular has brought about almost an explosive growth in the number of fields of special training ancillary to medicine. At the present time there are in the neighborhood of fifty categories of medical technicians. (See appended listing from a September 1959 survey prepared by the Law Division of the American Medical Association for the Committee to Study the Relationship of Medicine with Allied Health Professions and Services.)

"In Wisconsin there are licenses or certificates permitting limited practice in such varied fields as chiropody, physical therapy, professional nursing, and trained practical nursing.

"The question is presented from time to time, and exists at the present time, whether licensure or certification by the state is the most advisable process for establishing standards of education, examining credentials and abilities, and regulating the practice of such specially trained groups.

"The State Medical Society opposes the further extension of licensure, certification, or registration under Wisconsin law.

"Its reasons for doing so are:

"(1) A limited license seems to stimulate continuing efforts to expand the area of permitted practice without a corresponding expansion of training and qualifications.

"(2) Delegation to one holding a license or registration by the state may be argued as delegation of responsibility within the capacity of that individual to practice, where in fact, the responsibility of a physician and surgeon should be a matter of individual judgment on his part.

"(3) Licensure implies to the public skilled training and a right of freedom of practice within those skills, without necessarily defining the precise area of practice.

"These are among the more basic reasons. Others could be enumerated.

"The State Medical Society feels that the present program of voluntary certification, adaptable to the needs of the time, to the growth of the science, and particularly framed in light of practical considerations, will assure the public of a greater supply of these essential and valued assistants.

"However, the State Medical Society can at the best but express its views. Under some circumstances it might actively oppose state certification or licensing. It can not do other than bring its influence to bear, and that may at times be insufficient; or, indeed, the circumstances may arise where the Society would support such legislation.

"In any event, the Society believes that whatever legislation might conceivably be enacted in the future, these matters should be kept well in mind:

"(1) The group to be certified or licensed by the state should pay a sufficient amount for initial licensing and for annual registration as will assure the maintenance of proper records and the payment of a salary sufficient as to command administrative attention.

"(2) Any such legislation should have adequate provision for enforcement and should broadly outline proposals therefor.

"(3) Since such certification or licensure is ancillary to the field of medical practice, it would be proper and preferable that the board or committee be under the broad supervision of the State Board of Medical Examiners.

"(4) The fact of proposed enactment of such legislation should be widely known throughout the state so that persons to be affected by it may have ample opportunity to understand it and its application to them."

Appendix

Scientific, Professional and Technical Personnel in the Health Fields*

* A representative but not inclusive tabulation of persons, other than physicians, other than licensed practitioners of the healing arts, dentists, and nurses, who are engaged in investigation, treatment, and prevention of disease and disability, and in promotion of health by virtue of some special skill.

1. Anatomists
2. Audiologists
3. Basal metabolic technicians
4. Bioanalysts
5. Biochemists
6. Biophysicists
7. Biostatisticians
8. Chiropodists
9. Clinical Chemists
10. Corrective therapists
11. Cyto-technologists
12. Dietitians
13. Electrocardiographic technicians
14. Electroencephalographic technicians
15. Electrologists
16. Epidemiologists
17. Histologic technicians
18. Hospital administrators
19. Industrial hygienists
20. Inhalation therapy technicians
    (Oxygen therapy technicians)
21. Lay psychoanalysts
22. Masseurs and Mechano-therapists
23. Medical illustrators
24. Medical record librarians
    Medical record technicians
25. Medical social workers
26. Medical technologists
27. Microbiologists
    Bacteriologists
    Immuno-serologists
    Mycologists
    Parasitologists
    Virologists
28. Midwives
29. Music therapists
30. Nutritionists
31. Occupational therapists
32. Opticians
33. Optometrists
34. Orthoptic technicians
35. Pharmacists
36. Pharmacologists
37. Physical therapists
38. Physiologists
39. Prosthetists
40. Psychiatric social workers
41. Psychologists
    Clinical psychologists
    Counseling and guidance psychologists
42. Public health educators
43. Radiation therapy technicians
44. Recreational therapists
45. Rehabilitation therapists
46. Sanitary engineers
47. Sanitary inspectors
48. Speech therapists (speech pathologists)
49. Vocational counselors
50. X-ray technicians

Doctors Keane, Wunsch, Houfek, and Nereim were present during this order of business, and Doctor Keane discussed proposed legislation concerning clinical psychology on which no specific action was taken.

14. Report of Committee on Scientific Medicine

A. Pilot Course for Obstetrical Nurses

Doctor Evrard, chairman of the Division on Maternal and Child Welfare, reported on the pilot program just completed which had been authorized by the Committee on Scientific Medicine and Executive Committee of the Council. He requested authority to conduct a second program for training obstetrical nurses to meet emergencies, and if successful, to expand it further to other hospitals.

On motion of Doctors Bell-James, carried, the Council approved.

B. Public Meeting at Time of Annual Meeting

The Committee on Scientific Medicine reported that it had discussed the proposal authorized by the Council and concluded that appropriate arrangements could not be made in 1963.

C. Recommendations of Editorial Board

The committee reported its approval of proposals of the Editorial Board of the Wisconsin Medical Journal for a medical writing award, a medical photography contest, and two dedicatory issues of the Journal.

15. Report of Committee on Economic Medicine

The report of J. H. Houghton, M.D. on this committee's February 21 meeting follows, together with Council action upon it:

A. Survey of Business Practices of Physicians

"Doctor Willson stated that a business management firm in Wisconsin had surveyed about 400 physician clients and he reported in a general way on the results of the findings. Doctor Egan mentioned another survey of approximately 750 physicians by a similar firm. No details were available. Staff reported that other sources either would not or could not make available information concerning business practices of physicians in Wisconsin.

"Mr. Gill and Mr. White outlined a proposed survey of every doctor's office in Wisconsin for the purpose of obtaining basic data from which to provide information to all physicians concerning the cost of office operation. This would include the areas of billing and collections, fee production, expenses relating to payment records, professional development, entertainment, special costs, office expenses, rental, and the like.

"On motion of Doctors Schulz–Blanchard, carried (Doctors Willson and Nadeau recorded as opposed), the Committee recommends to the Council that the State Medical Society undertake such a survey and that the consulting CPAs immediately prepare a revised and simplified form to be used in the survey. The Committee would evaluate the returns from the survey prior to development of financial data and reports."

On motion of Doctors Houghton–Dessloch, carried, this portion of the committee report was approved.

B. Health Care of the Aged in Terminal Illness

"Doctors Blanchard and Houghton reported on local studies which they did concerning the deaths of persons aged 65 and over in hospitals in Columbia and Ozaukee Counties. Doctor Blanchard had detailed information concerning deaths both in and out of the hospital for persons 65 and over for the period of July 1, 1960, to June 30, 1961. Analysis of these 126 deaths reveals that each was under the care of a physician at the time, and in a high percentage of instances had undergone hospitalization or nursing home care varying from several years to a few hours prior to death.

"The Committee also reviewed statistical reports from the U. S. National Health Survey of 1957 indicating that approximately 56% of deaths in the nation had occurred in hospitals and that a very high proportion of all people experienced some hospital care in the last hours of life. It was pointed out that 83% of those over 65 who died during 1957, and had hospital care, died in the hospital. The percentage of deaths of persons over 65 occurring in general hospitals decreased with advanced age because older people have greater utilization of long term hospitalization and nursing homes.

"On the basis of all data available to the Committee, it is apparent that a very high proportion of those who died in Ozaukee County in the period under study received some hospital care and almost 100% received some medical care during that year. These views cast considerable doubt on the allegation that people are denied care or deny themselves care and do so because of financial reasons. The Committee believes that its study exposes the fallacy of the charges that 'thousands of persons are dying for lack of medical care.' On the contrary, it is significant evidence that few, if any, persons die in the State of Wisconsin for lack of medical attention.

"It is the opinion of the Committee that persons over 65 are receiving medical care if they need it, and it suggests that the information collected by the Committee be discussed with appropriate Divisions of the AMA to determine whether further studies in depth might prove of considerable assistance in providing effective factual data and arguments in discussions concerning health care of the aged."

No action by the Council.

C. Medical Economic Conference

"The Committee has authorized the establishment on a trial basis of an economic institute to be held in Madison. The total attendance is to be limited and a registration fee charged.

"If the trial institute proves successful, consideration would be given to conducting them elsewhere around the state.

"On motion of Doctors Willson–Blanchard, carried, the Committee recommends that such an institute be held in Madison in mid-October, 1963, with attendance limited to about 180 persons and with a registration fee of $15 to cover the attendance of two persons (the physician and his accountant or his attorney or both of the latter, for example). Subjects would include taxes, insurance planning, personal corporations and H.R. 10, and internal management and accounting control.

"It is anticipated that the Conference can be presented on a maximum budget of $2,000. Registration fees are expected to produce about $1,500 of income. The availability of certain important out-of-state speakers without honorarium is a possibility, thus reducing the expenses, but it could well be that approximately $500 of the Conference costs would need to be borne out of the dues account."

On motion of Doctors Schulz–Blanchard, carried, the recommendation was approved as presented including the necessary expenditure.

D. Distribution of Gamma Globulin

"Doctor Houghton reported that the method of distributing gamma globulin by the State Board of Health poses economic difficulties for the physicians whose commercially purchased supply of gamma globulin might be used to provide the protection necessary to his patients at the time it can be effective. The State Board of Health supplies the gamma globulin but it frequently arrives at the physician's office after the heavy period of usage and becomes outdated before it is again needed.

"The Committee agreed that the Commission on State Departments should be requested to study the matter and report to the Council."

E. Reasonable Choice of Physician in Industry

"Doctor Nadeau expressed some concern at the use of limited panels of doctors in some industries. Doctor Houghton requested that the matter be discussed further at a subsequent meeting if there appears to be evidence of a breakdown in the requirement that all plants provide the employee with 'reasonable' choice of physician."

On motion of Doctor Blanchard, seconded and carried, the report of the Committee on Economic Medicine was approved.

16. Report of Finance Committee

A. Revisions in Employees' Group Insurance

Doctor Dessloch reported that the committee had approved adjustments in the group life and disability coverage at minor additional cost to the Society. These were recommended by the Society's insurance consultants to bring its program to the competitive level of industry.

Group life insurance will be in the amount of $3,000 for employees whose annual salary is less than $4,800, and for those above that amount, life insurance equal to one and one-half times the annual salary, with a maximum of $40,000. There is employee contribution in the latter classification. Changes in the long-term disability coverage place certain female employees in the category with male employees and extend sickness benefits to five years, all employees to receive lifetime benefits for accidental disability.

B. Employees' Pension Plan

As trustees of the plan, the Finance Committee accepted the secretary's certification of 19 employees as eligible to participate, and approved the payment from general funds rather than the trust of an amount in dispute at the termination of Paul Doege.

C. Society Budget for 1963

Doctor Dessloch reviewed the budget as distributed to the Council. The account totals were as follows.

Dues—Membership and Supporting	$ 1,455
Conference Expense—Council and committee meetings, officers' travel, etc.	26,250
Promotion	7,650
Depreciation	3,200
Grants and Appropriations	7,200
Insurance—General	2,700
Miscellaneous Expense	2,500
Office Supplies and Expense	3,500
Outside Services	7,750
Postage	12,000
Printing and Forms—including publication expense of WMJ	56,450
Rent—Office	32,000
Rent—Other	7,000
Rental—Other Equipment	750
Repairs and Maintenance of Equipment	1,000
Resource Material	975
Speakers' Expense	4,500
Property Tax—Personal Property	350
Telephone	3,400

Accounting Services	4,000
Legal Services	7,200
Legislative Retainer	8,900
Special Budgetary Provisions*	24,080
Subtotal, Operating Budget Totals	$224,810
Staff Travel Expense	7,150
Payroll	124,000
Related Payroll Expenses	14,500
Field Service	26,200
Total SMS Budget, 1963	$396,660
Total Anticipated Income	$396,710

Salaries of the chief executives were maintained at the level of the year indicated:

C. H. Crownhart, secretary and general manager	$30,000	(1958)
Earl R. Thayer, assistan secretary	19,400	(1961)
Roy T. Ragatz, assistant secretary (part time)	7,250	(1960)

* Special budgetary provisions included the Wisconsin Work Week of Health; the Conference on Health Fads and Fallacies; and the mailing on a complimentary basis of *AMA News* and *Today's Health* to civic leaders in Wisconsin.

On motion of Doctors Dessloch–Ekblad, carried, the report of the Finance Committee, including the budget, was adopted.

17. Resolutions for Introduction to American Medical Association

On motion of Doctors Nordby–James, carried, the Council authorized introduction of resolutions (1) calling for continuation of the chiropody study to determine the possibility of uniform legislation in the country; and (2) requiring fiscal notes on projects requested at the national level.

The Council then recessed to meet as members of the SMS Realty Corporation, and reconvened after lunch at 1:25 p.m.

18. Educational Programs for Osteopaths

Doctor Evrard requested specific direction from the Council regarding the proposal that an educational program on maternal problems be presented at the Wisconsin Osteopathic Association convention.

On motion of Doctors Dessloch–Bell, carried, the Council advised that until its action in adopting the "Statement on Osteopathy" reported above is known and implemented by county medical societies, the State Medical Society should not present an educational program at the osteopathic meeting, but should initiate at the appropriate time a program arranged by and under the auspices of the State Medical Society.

19. Executive Session

The Council held an executive session at the request of Doctor Lokvam to discuss the matter of interpretation of the WPS Special Service contract.

During the executive session the Council approved nominees for the Council Award and Presidential Citation.

20. Statement on Compulsory Retirement

On motion of Doctors Houghton–Ekblad, carried the following statement was adopted:

"Arbitrary retirement based solely on chronological age is widely regarded as undesirable in a free society which places a premium on individual accomplishment and dignity. This concept of retirement is clearly and positively stated in the eight-point program for the aged issued by the American Medical Association on February 19, 1963:

"'The AMA favors flexible policies which utilize the talents and abilities of employees as long as they are willing to work and are productive. Compulsory retirement and employment policies which reject workers solely because of age waste valuable human resources and contribute to physical and mental illness among the aged.'

"The State Medical Society wholeheartedly endorses this statement of policy and applies it to Bill 146, S. which, with some exceptions, would force the retirement of all employees of the state at age 65.

"Such a policy would deny these citizens the right which gave their life meaning prior to age 65—the right to work for the state. It ignores the fact of longer life and more alert living at older ages, to which modern medical care has contributed so much.

"It is unrealistic in light of the facts now available concerning the rising cost of supporting the older person in retirement, the recognized value of the older worker and the obvious contributions which he can make to society if his potential is properly used.

"The State of Wisconsin should instead provide leadership to industry and labor in this state by the adoption of truly flexible programs of retirement which recognize individual worth and initiative."

21. Reports of Council Committees to House of Delegates

On motion of Doctors Ekblad–Dessloch, carried, the Council authorized its Executive Committee to clear annual reports for circulation to the delegates.

22. Portage County Medical Society Charter

On motion of Doctors Schulz–James, carried, the Council approved reissuance of the Portage County Medical Society charter as of the date of original issue in 1904.

23. State Laboratory of Hygiene

On motion of Doctors Dessloch–Lokvam, carried, the Council affirmed the position that joint operation of the State Laboratory of Hygiene by the University and the State Board of Health is preferable to its operation by one or the other only.

24. Standard Casualty Medical Report Form

On motion of Doctors J. H. Houghton–Davis, carried, the Council approved for distribution to all physicians a standard casualty medical report form prepared by the Wisconsin Claims Council working with President Hill.

25. Committee on Health Economics of American Life (HEAL)

The committee met Saturday afternoon, and reported its proposal to gain a core of speakers throughout the state by asking each county medical society to send a representative to an AMA legislative conference in Chicago in April.

26. Staff Report

A. New Look of Medical Exhibits

Mr. Ragatz described the new type of "free form" exhibits which are beginning to appear at some meetings and may in time be tried in Wisconsin.

B. Events Scheduled at Society Headquarters

Mr. Crownhart reported that at the request of the AMA, the Society would entertain at lunch and arrange tours of the vicinity for a group of French rural physicians, and that a Poison Control Seminar would be held at the building.

27. Adjournment

The Council adjourned at 2:20 p.m.

C. H. CROWNHART,
Secretary

Approved:
JAMES C. FOX, M.D.
Chairman

Minutes of Special Council Meeting

Madison, April 6, 1963

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 2:15 p.m. on Saturday, April 6, 1963, at Society headquarters in Madison.

All councilors were present except Doctors Schulz, Ekblad, and Van Hecke. Officers and others present were President Hill, President-elect Egan, Speaker Callan, Vice Speaker Carey; AMA Delegates Simenstad, Bernhart, and Hildebrand. Staff and consultants: Messrs. Crownhart, Ragatz, Thayer, Toser, Murphy, Robison and White; Mrs. Anderson and Miss Pyre.

2. Approval of Minutes

On motion of Doctors Frank–Blanchard, carried, action on minutes of the last meeting was dispensed with at this special meeting.

3. Executive Committee and Staff Recommendations on Report of Booz, Allen and Hamilton, Inc.

The secretary, by way of review, reported that the Executive Committee had met with the Management Survey Committee on March 23, and had subsequently decided to call a special meeting of the Council for consideration of the status of the Booz, Allen and Hamilton report. The Executive Committee had met again the morning of April 6 and concluded that the staff analysis of the report should be presented to the entire Council. This had been prepared for the March 23 meeting but the opportunity did not present itself for the staff to make their presentations at that time, when the two committees met in executive session.

Doctor Fox asked the staff members and consultants who had prepared analyses to report, and ruled that there would be no recording until discussion began.

Doctor Willson then moved that the subject be referred to the Speaker of the House of Delegates with instructions to confer with the special committee as to means whereby it can be presented to study committees of the House of Delegates for evaluation and final recommendation. The motion was seconded by W. J. Houghton, M.D., and discussion ensued which Council members asked be recorded in the minutes:

Doctor Nordby: My impression is that this discourse will be of value to us to determine, besides our own thinking, the impressions of those on the staff who have analyzed various sections of it. We don't have to agree or disagree with their impressions. I would be interested to hear their impressions. It was my understanding this is to be transmitted intact to the House of Delegates no matter what we think of it.

Doctor Fox: Doctor Willson, I was debating with myself as to whether or not your motion was out of order, not because of anything wrong with the motion you made, but because of the fact that the motion pertains to the way this report is to be handled from here on in. We cannot change this report one bit. This is a report which will be submitted by the management survey committee to the House of Delegates. This is merely for the information of the Council as the policy-making body of the State Medical Society between sessions of the House of Delegates as to the adequacy of this report. Therefore, I do not believe your motion is in order because there is nothing that the Council can do to alter this report, change it, or change its method of transmittal. It is to be transmitted by the management survey committee to the House of Delegates.

Doctor Willson: Are you ruling my motion out of order?

Doctor Fox: Yes.

Doctor Willson: I appeal to the ruling of the chair for a vote. I wish this to be recorded in the minutes.

Doctor Dessloch: Probably not enough background has been made available for this discussion. Transmittal of this report will have to be by the management survey committee and no other. The only thing that I think the Council was brought together for here today, and that is what the Executive Committee thought this morning when they met, was the information that you will get as a result of looking at this report and having various and sundry people discuss it, including yourselves. As I understand it, there will be no formal action taken on this in any way except to say to the management survey committee that there is a view that the Council has, if they so desire, and that is all this is about today.

Doctor Fox: I perhaps am in error because I should have explained this at the beginning of the meeting. The management survey committee wants our reaction to this report.

Doctor Willson: I don't object to that.

Doctor Fox: That is all we want to do.

Doctor Houghton (W. J.): When are the delegates going to get the report?

Doctor Fox: I don't know.

Mr. Crownhart: The thought of the Executive Committee was that you should have the staff analysis which nobody has as yet received; that the survey committee will itself undertake the distribution of the report. Doctor Suckle has already contacted me with reference to some phases of that. It is at the printer being photographed. We didn't get it until Tuesday. One thousand copies have been ordered at a cost of approximately $7,000. They should be available about the 15th or 16th. If Doctor Suckle's committee orders its distribution, as I am sure it will, the delegates in the state and alternates will have the report about April 20.

Doctor Fox: One thing must be borne in mind by all of you. There has been a lot of discussion throughout the state about the way the Council at times changes reports, etc., most of which are without any basis of fact. This report will not be changed one paragraph, one comma, one period.

Doctor Dessloch: If we are out of order at all in discussing the motion or anything else, it should be on the basis that the Council has no jurisdiction as to how to get it to the Speaker of the House. We can't recommend the way in which that should be done because it has to be done through the special survey committee.

Doctor Fox: That is the reason I declared Doctor Willson out of order.

Doctor Willson: I still think the membership of the State Medical Society and the delegates at large, that this is their problem. I cannot see why the motion is out of order. It simply gives the Council a chance to keep its skirts clean.

Doctor Fox: We have no authority to determine how it is distributed. (He then called for the vote on supporting the ruling of the chair.)

No: Doctors Willson and W. J. Houghton.
Aye: Doctors J. H. Houghton, Nordby, Davis, Dessloch, Blanchard, Kief, Nadeau, Bell, Mason, Frank, Chojnacki, Hollenbeck, Curran, James and Lokvam.

Doctor Willson requested "this byplay be recorded in the minutes."

Doctor Dessloch: I think if the minutes are going to show this vote, then the reasons for and against are also in the minutes.

Analyses were then presented by Messrs. H. L. Toser, E. R. Thayer, R. T. Ragatz, J. B. White, and C. H. Crownhart.

Discussion followed in which Doctor Callan asked whether the staff reactions had been transmitted in writing to Booz, Allen and Hamilton. Doctor Fox read the motion adopted by the Executive Committee in its January 19 meeting with the management survey committee and representatives of Booz, Allen and Hamilton "that the secretary of the State Medical Society, and a representative of the Medical Society of Milwaukee County be authorized to confer with the special committee on the management survey and with the firm of Booz, Allen and Hamilton on the full proposed report, such conferences to cover the scope and accuracy of the portion of the report pertaining respectively to each organization."

Mr. Crownhart replied to Doctor Callan that "they were not pending authority of the Executive Committee and the management committee to meet with them or not to meet with them because the report was, in our judgment, so far off base."

There was also discussion of the possibility of Booz, Allen and Hamilton presenting its report to the House of Delegates which would no doubt entail the expenditure of more than the $40,000 top estimate of the management firm. Doctor Callan pointed out that more than this had been collected from the special assessment, and the House of Delegates had not placed a $40,000 limit on the survey. Mr. Crownhart reminded the Council that costs incurred by the State Society, and those reported by county societies, in meeting the demands of the management consultants are to be charged against the special assessment fund. He thought that the cost of reproducing the report was a legitimate charge against it, as well as special meetings of the Executive Committee and Council, and said that total costs of the management survey must not be allowed to exceed the amount raised by the special assessment.

Doctor Nordby moved that the comments as given by the members of the staff be released to the management survey committee to do with as they see fit; seconded by Doctor Blanchard.

Doctor Houghton (J. H.) offered an amendment to add the words "if requested"; seconded by Doctor Blanchard.

The amendment lost by a vote of 9 to 5 and the motion carried.

There were questions as to when and how the management survey intended to present the report to the delegates and alternates and interested officials of the Society, and whether it would be a subject for discussion at the delegate caucuses. Doctor Fox said the Council could only make a recommendation to the management survey committee.

On motion of Doctors Willson–Dessloch, carried, the Council recommended to the management survey committee that it forward the survey and comments to each delegate and alternate at the earliest possible moment.

4. L. H. Lokvam, M. D.

Doctor Lokvam asked for further opportunity to discuss the matter he had presented in executive session at the February Council meeting, relating to his local county insurance advisory committee's interpretation of the WPS Special Service program. His position was that the committee should be advised as to the philosophy of the WPS Special Service contract; that it is subject to the same interpretation state-wide as providing the usual, customary and reasonable range of fees.

Mr. Crownhart said that the Executive Committee of the Commission on Medical Care Plans intended to meet with the county committee, but there had been a conflict in dates and such a meeting had not yet been held. Doctor Dessloch said that following the Council meeting at which Doctor Lokvam reported in executive session, when the Executive Committee of the Commission was asked to deal with the matter, it did discuss the problem and took the position that where a county advisory committee is fairly composed and functioning, strong and valid reasons must be presented to overrule its findings. If there is some question of prejudice, this belongs in the Grievance Committee.

After discussion, on motion of Doctor Nordby, seconded and carried, the matter was referred to the Commission to ask the county committee to meet for information.

The Council recessed at 6:00 p.m. and reconvened at 7:30, Doctor Bell presiding.

5. Resolutions to Offer the American Medical Association

The Council took action on the wording of resolutions previously authorized:

(a) On motion of Doctors Frank–James, carried, the Council approved the following resolution on chiropody:

Resolved, That the American Medical Association continue its studies of chiropody (podiatry) to determine if a uniform law can be recommended for enactment by all states defining their scope of practice, permitted procedures, and use of diagnostic and therapeutic devices.

(b) On motion of Doctor Houghton (J.H.), seconded and carried, the following resolution on financing of AMA projects was approved, subject to review and editing by Doctor Blasingame:

WHEREAS, Many resolutions of individual state delegations and others calling upon the American Medical Association for some new program are of such character as to involve expenditures of substantial funds as well as impact upon staff time and availability; now, therefore, be it

Resolved, That unless declared to be of an emergency nature by the Speaker of the House, such proposals shall be forwarded to the Board of Trustees for a fiscal and management note with reference to the items listed, and returned to the House at that or the next following session for further consideration.

(c) Dispensing by Physicians

Doctor Bell explained that Doctor Quisling, who could not be present at the Council meeting, had proposed a resolution on this subject. He said that subsequent to its drafting, the *AMA News* of April 1 had reported the present position of the Judicial Council, and the Executive Committee felt that this should be endorsed rather than a resolution introduced.

On motion duly made, seconded and carried, the Council supported the present stand of the Judicial Council of the AMA.

6. Official Communications

(a) Governor Reynolds

On motion of Doctors Kief–Blanchard, carried, the Council approved a communication by Doctor Hill to the Governor offering the Society's services and advice with reference to physicians under consideration for appointment to state boards.

(b) University of Wisconsin President Harrington

On motion of Doctors Blanchard–Kief, carried, the Council approved a communication by Doctor Hill to President Harrington inviting a meeting with the Board of Regents.

Doctor Kief suggested that a similar invitation be extended to the Executive Committee of Marquette University School of Medicine, and the Council accepted Doctor Bell's appointment of Doctors Kief and Curran to ascertain during the course of the annual meeting honoring Marquette whether there was interest in a joint meeting.

(c) Reception for W. J. Egan, M.D., as President

The Executive Committee recommended a suggestion of Doctor Hill that a reception be held at Society headquarters honoring the incoming president, to which the Governor and other state officials, United States government officials from Wisconsin, University officials and others would be invited.

There was discussion of costs of such an event. Doctor Dessloch, chairman of the Finance Committee, said that new projects of merit can be accommodated after the budget is set, but it means that something else must be forgone. Doctor Nadeau and others felt this would be a worth-while expenditure, and thought it should be related in the budget to public policy activities.

On motion of Doctors Blanchard–Kief, carried, the Council approved the recommendation.

7. Statement on Two Sessions of the House of Delegates Annually

Copy of a statement recommended by the Executive Committee was distributed to the Council, proposing that the House of Delegates meet as usual during the annual scientific meeting for election of officers and reception of a limited number of reports, and meet again in the fall at Society headquarters for a concentrated business meeting.

Doctor Kief favored the recommendation, but asked how it would be decided what reports are made in May. The secretary gave his recommendation that the Council report at both meetings, and the Commission on Medical Care Plans; that some, not necessarily all, of the officers would have reports at both; that the legislative report would vary in volume. He pointed out that not all of the 10 divisions of the Commission on State Departments were ready to report in May.

On motion of Doctors Curran–Nordby, carried, the statement was approved for transmittal to the House of Delegates.

8. Bill 131, A.—Blue Cross

Mr. Murphy discussed the bill and its current status as well as amendments which have been offered. After discussion of the alternative positions that might be taken by the Society:

On motion of Doctors Nordby–Nadeau, carried, the Council voted to amend section 2 of the bill to include language from the cooperative sickness care law, and to oppose section 3 of the bill.

9. Proposed Meetings

On motion of Doctors Blanchard–Houghton (J.H.), carried, the Council approved the extending of invitations to joint meetings to the State Board of Medical Examiners and to the State Board of Health.

10. Executive Session

Action taken during the executive session was a motion by Doctors Nordby–Blanchard, carried, that the reports earlier outlined by the secretary be submitted at the May meeting.

11. Adjournment

The Council adjourned at 9:20 p.m. with a rising vote of thanks to Earl R. Thayer whose resignation as of October 1, 1963, was announced during the meeting.

C. H. CROWNHART
Secretary

Approved:

JAMES C. FOX, M.D.
Chairman

Dr. W. J. Egon (center), Milwaukee, receives the president's gavel from Dr. N. A. Hill, Madison, past president of the Society. Looking on is the president-elect, Dr. W. P. Curran, Antigo.

Dr. W. J. Egan (left), Milwaukee, receives the oath of office as the new president of the Society from Dr. James C. Fox, LaCrosse, chairman of the Council.

Harry Steenbock, Ph.D., emeritus professor of biochemistry at the University of Wisconsin, receives the Society's highest honor, the Council Award, from Dr. N. A. Hill, Madison, past president of the Society.

SUMMARY REPORT

122nd ANNUAL MEETING

HOUSE OF DELEGATES

Milwaukee, MAY 6–9, 1963

Management Survey Report

The House received the report of Booz, Allen & Hamilton without recommendation, and voted to appoint a seven-man committee to review and study the survey and make appropriate recommendations at the next meeting of the House.

The committee will consist of two members appointed by the president, two appointed by the Council, and three appointed by the speaker and vice speaker of the House. The president, speaker and vice speaker will serve as ex-officio members.

Copies of the report have been distributed to delegates, alternates, officers, and each county medical society. Copies are also available, on a loan basis, to individual State Medical Society members on request.

Resolutions

No. 1—Invitation to hold 1964 annual meeting in La Crosse; not accepted, with regret, because of prior commitments.

No. 2—Concerning management survey report; withdrawn.

No. 3—As amended, limiting physician participation in scientific programs of the Society to members and invited out-of-state guests; adopted.

No. 4—As amended to, furnish detailed financial statement of the Society, including salaries of employees, to the House; rejected.

No. 5—A special page or column in the *Wisconsin Medical Journal* polling the membership on various topics, with a quarterly reporting procedure of results; rejected because of lack of fiscal note but suggestion forwarded to editor for consideration.

No. 6—Proposed legislation on financing medical care for the aged; rejected.

No. 7—Changing title of Section on Neurology and Psychiatry; rejected.

No. 8—As amended, urging county medical societies to provide authorized emergency care personnel with instruction in external cardiac massage; adopted.

Members of the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws: Drs. R. F. Purtell, Milwaukee; E. P. Rahde, Galesville; G. A. Behnke, Kaukauna; C. W. Stoops, Madison; C. J. Picard, Superior, chairman; L. E. Fazen, Jr., Racine; and D. R. Griffith, Eau Claire.

No. 9—As amended, reaffirming that services of pathologists and radiologists in and out of hospital be insured under the medical service portions of WPS contracts; adopted.

Nos. 10, 13, 14—Internship training programs; not accepted because of ambiguity, but AMA delegates urged to express concern of future of internship programs in private hospitals.

No. 11—Distribution of management survey report; declared out of order.

No. 12—No meetings be scheduled to conflict with the annual dinner of the Society; adopted.

No. 15—Opposing federal regulation of animals in research; adopted.

Constitutional Amendments

Three constitutional amendments which received final approval of the House of Delegates:

. . . give the president and speaker of the House of Delegates the right to vote as ex-officio members of the Council and establish a majority of the voting members as a Council quorum.

. . . provide that no person shall hold more than one of the following offices concurrently—president, president-elect, secretary, treasurer, councilor, speaker or vice speaker of the House of Delegates.

. . . extend the term of office of the speaker of the House of Delegates from one to two years.

Two Meetings of the House of Delegates Each Year

The House approved a recommendation of the Council that two meetings of the House be held each year. Among the reasons given—the volume of material which must be acted on by the House each year, conflict with legislative activity every other year. The first additional session will be held October 18–19, 1963, at the Society headquarters in Madison.

Kerr-Mills Law Implementation

Called for bipartisan support of Bills 408, S. and 647, A., to implement Kerr-Mills in Wisconsin. The bills permit the Blue plans of Wisconsin and licensed insurance companies to contract through the state to administer hospital, nursing home, dental, drug, nursing and medical benefits for those senior citizens who need that type of special assistance. Each county medical society is urged to utilize newspapers, radio and television to the extent possible to promote passage of this enabling legislation.

Members of the Reference Committee on Reports of Standing Committees: Joan Pyre, staff secretary; Drs. John E. Martin, Jr., Delavan; G. W. Hilliard, Milwaukee; F. E. Gehin, Stevens Point, chairman; W. T. Russell, Sun Prairie; and J. V. Balger, Jr., Milwaukee.

Members of the Reference Committee on Reports of Officers: Drs. L. W. Schrank, Woupun; J. F. Walsh, Port Washington, chairman; C. J. Strang, Borron; Patricia Moron, staff secretary; Drs. F. M. Hilpert, Racine; and H. W. Twelmeyer, Milwaukee.

Osteopathy

Approved a Council statement of policy that "voluntary professional relations between a Doctor of Medicine and a Doctor of Osteopathy should not be deemed unethical" if the county medical society determines, on an individual basis, that the Doctor of Osteopathy meets five criteria. With the consent and advice of county medical societies, the Society will encourage such Doctors of Osteopathy as meet these standards to attend appropriate programs of postgraduate education.

Special Conferences

Approved a Conference on the Extension of Voluntary Health Insurance for Fall, 1963, to bring together all forces interested in expanding the breadth and scope of voluntary health insurance—labor, management, commercial and nonprofit insurance plans, state governmental agencies, and associations and organizations representing or related to segments of medical care.

Suggested that the Wisconsin Work Week of Health and Conference on Health Fads and Fallacies be continued on an annual basis.

Compensation of House Officers

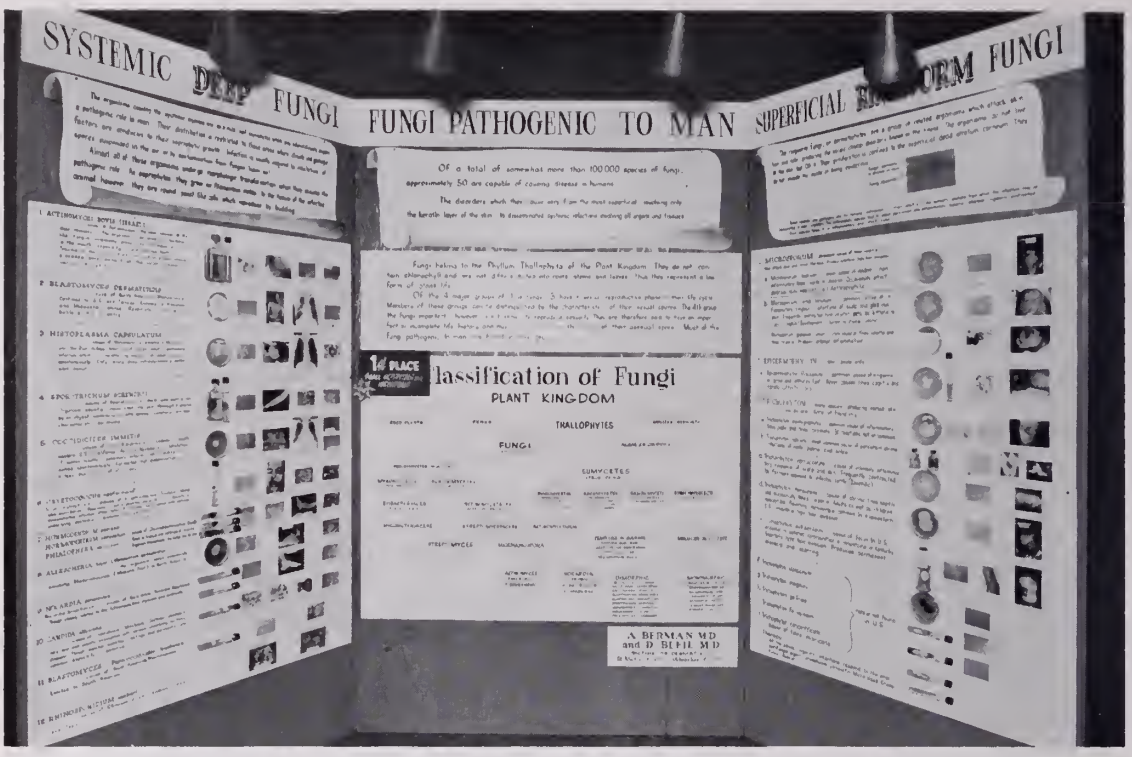
Acting on report of AMA delegate R. E. Galasinski, M.D., declared that compensation of house officers involves problems of: salary, financing of training programs, techniques of collection of funds, unnecessary competitiveness which might result. AMA delegates, cognizant of these problems, are to represent the Society accordingly.

Committees, Commissions and Divisions

PUBLIC POLICY

Listed major bills being considered by the Legislature and urged members to contact Senators and Assemblymen concerning them.

Past presidents of the State Medical Society who attended a luncheon in their honor are shown below: (seated) Dr. W. J. Egan, president, Milwaukee; Dr. N. A. Hill, immediate past president, Madison; Dr. W. P. Curran, president-elect, Antigo; Dr. E. L. Bernhart, Milwaukee; Dr. H. Kent Tenney, Madison; Dr. K. H. Daege, Marshfield; (standing) Dr. M. A. McGarty, La Crosse; Dr. Harry E. Kasten, Beloit; Dr. E. D. Sorensen, Elkhorn; Dr. W. D. Stovall, Madison; Dr. L. O. Simenstad, Osceola; and Dr. A. J. McCarey, Green Bay.



FIRST PLACE, small hospitals and individuals: "Fungi Pathogenic to Man." Drs. Alexander Berman and D. C. Bleil, St. Michael Hospital, Milwaukee. The exhibit presented a classification of fungi and basic information relative to fungi and fungous diseases. Cultures of the common organisms were demonstrated and the particular organism was related to its most characteristic clinical patterns. Photographs demonstrated typical features of the clinical disorder produced. Clinical usefulness and mode of action of system antifungal agents was noted.

COMMISSION ON SCIENTIFIC MEDICINE

Scientific teaching programs of the Society in the past year had an attendance of 540 persons and the Speakers Service provided 62 scientific programs reaching 1,770 physicians.

The House suggested continued effort to explore all methods of mass communication to bring programs of widespread interest into the immediate locale of the practicing physician by use of taping, closed circuit television and telephone circuit.

COMMITTEE ON DISASTER MEDICAL CARE

House approved report urging county medical societies and individual physicians to provide leadership for medical self-help training programs within their own communities and encouraging physicians to fill medical vacancies within the Civil Defense organization in their communities.

COMMISSION ON MEDICAL CARE PLANS

The House commended the Commission for its direction of Wisconsin Physicians Service and the progress made in attaining desired goals.

WPS reported over $11 million in earned premiums in 1962, surgical-medical contract count of over 100,000, reserves at an all-time high, and consolidation of entire staff in one building. The House requested a more detailed report, including financial data, in the future.

DIVISION ON CHEST DISEASES

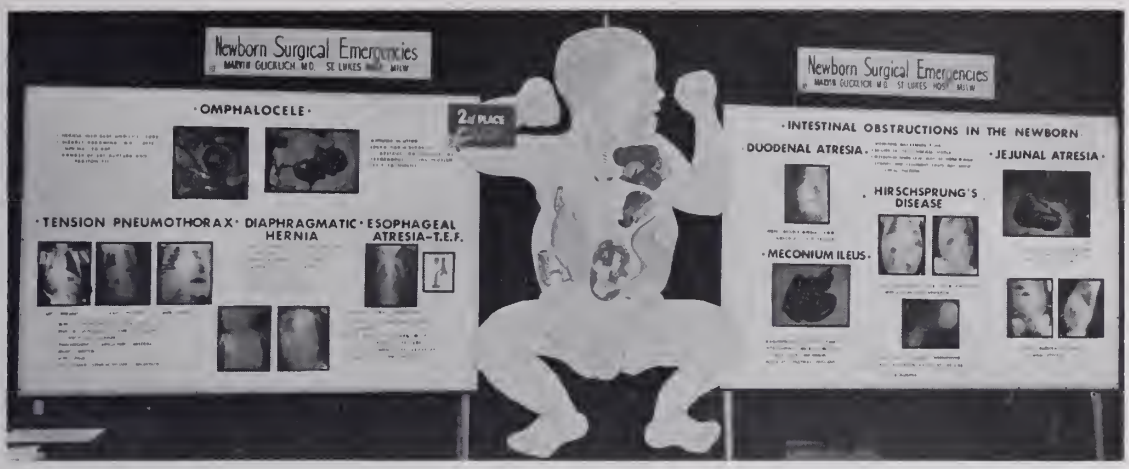
House approved report recommending: utilization of State Board of Health tuberculin and hypertension screening units, support for development of outpatient dispensaries for known cases of tuberculosis and other pulmonary diseases.

DIVISION ON HANDICAPPED CHILDREN

House approved report recommending: continuation of orthopedic clinics in counties where they help the family physician to meet special problems, and continued utilization of hearing conservation, bicillin prophylaxis, and cleft palate programs.

DIVISION ON MATERNAL AND CHILD WELFARE

House approved report of: a special pilot program to train nurses to be of greater assistance to physicians in obstetrical cases which may be expanded for the benefit of smaller hospitals in the state, and clarified its position on the State Board of Health administrative ruling on administration of oxytocics —that the procedure requires immediate supervision of a physician, and further, that this requirement is met if adequate medical coverage is available in the



SECOND PLACE, small hospitals and individuals: "Newborn Surgical Emergencies." Dr. Marvin Glicklich, Department of Surgery, St. Luke's Hospital, Milwaukee. The urgency of early diagnosis and treatment of surgical emergencies of the newborn was stressed. Tension pneumothorax, diaphragmatic hernia, esophageal atresia and trachea-esophageal fistula, intestinal obstructions, and omphaloceles were depicted and discussed with x-ray films, transparencies, drawings, and diagrams.

hospital and known to the nurse observing the patient.

DIVISION ON SAFE TRANSPORTATION

House approved report recommending endorsement of the principle of "implied consent" for chemical tests for intoxication with specific legislative proposals to be evaluated and considered by the Society for active support.

DIVISION ON SCHOOL HEALTH

House approved report: urging physicians to make health appraisals of school children worth-while learning experiences for the child, parent and teacher, as well as fact finding procedures, and urging county medical society representatives and school administrators to establish liaison and bring about continued cooperation in the area of school health.

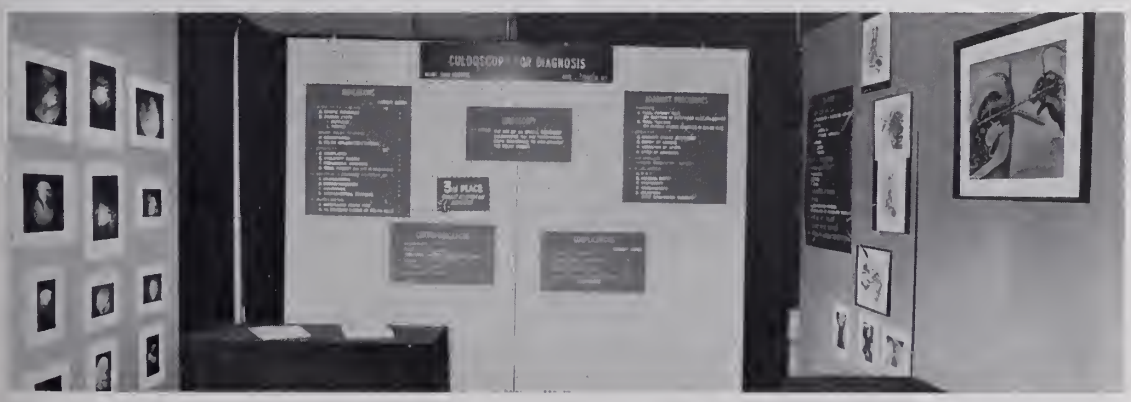
DIVISION ON VISUAL AND HEARING DEFECTS

House approved report recommending Society sponsorship of an instruction course for training audiometric technicians to perform hearing testing programs in industry under medical supervision, and alerting physicians to efforts of non-medical personnel to gain recognition and permission to participate in hearing testing screening programs in schools and industry.

DIVISION ON NERVOUS AND MENTAL DISEASES

House approved report recommending: establishment of a steering committee to establish liaison between the many organizations and interests in the field, a pilot program to provide postgraduate education in psychiatry for general practitioners, and a series of one-day teaching programs on the mildly retarded child.

THIRD PLACE, small hospitals and individuals: "Culdascopy for Diagnosis." Dr. C. J. Levinson, Milwaukee. A summary of the indications, technique and complications of culdascopy were presented. Personal cases and pictures were reviewed. A mannikin was used for demonstration of the instrument and technique.



FIRST PLACE, large hospitals: "Renal-Retinal Pathology." Drs. D. A. Roth and B. J. Peters, Wood Veterans Administration Center, Wood, A teaching exhibit, it presented Kodachrome enlargements of various renal tissues obtained by renal biopsy. Funduscopic photographs of co-existing retinal pathology were displayed in paired panels. In addition, a projector and screen were utilized to demonstrate correlation of retinal and renal abnormalities in various disease states. Normal and abnormal findings were shown.

Elections

OFFICERS

President: W. J. Egan, M.D., Milwaukee
President-elect: W. P. Curran, M.D., Antigo
Past president: N. A. Hill, M.D., Madison
Speaker: Robert E. Callan, M.D., Milwaukee
Vice-speaker: H. W. Carey, M.D., Lancaster

AMERICAN MEDICAL ASSOCIATION

Delegates: A. A. Quisling, M.D., Madison; R. E. Galasinski, M.D., Milwaukee
Alternates: George Collentine, Jr., M.D., Milwaukee; W. B. Hildebrand, M.D., Menasha

COUNCILORS

1st District: W. D. James, M.D., Oconomowoc
2nd District: G. J. Schulz, M.D., Union Grove
3rd District: C. W. Stoops, M.D., Madison
11th District: V. E. Ekblad, M.D., Superior
12th District: L. J. Van Hecke, M.D., Milwaukee; W. J. Houghton, M.D., Milwaukee
13th District: Marvin Wright, M.D., Rhinelander

Awards

COUNCIL AWARD

Harry Steenbock, Madison, emeritus professor of biochemistry, University of Wisconsin.

PRESIDENTIAL CITATION

Father Edward J. O'Donnell, S. J., chancellor of Marquette University.

Exhibit Awards

SMALL HOSPITALS AND INDIVIDUALS

First—St. Michael Hospital, Milwaukee, "Fungi Pathogenic to Man."

SECOND PLACE, large hospitals: "Lymphoid Cell Variations in the Peripheral Blood." Drs. E. L. Bemis, R. S. Haukohl, and Yoshira Taira, Department of Pathology and Laboratory Medicine, Evangelical Deaconess Hospital, Milwaukee. The exhibit contained illustrations and enlarged photomicrographic transparencies, showing morphologic variations of lymphocytes found in the peripheral blood in health and in disease; i.e., viral diseases, leukemia and lymphosarcoma.

THIRD PLACE, large hospitals: "Correlation of X-ray and Sigmoidoscopic Findings in Ulcerative Colitis." Drs. G. W. Sengpiel, R. T. McCarty, J. J. Wallerius, J. F. Wepfer, and A. E. Fitz. St. Joseph's Hospital, Milwaukee. Patients with ulcerative colitis were followed as to the progress of the colitis, by repeated radiological examination of the colon, as well as by periodic sigmoidoscopic examinations. The degree of change (improvements or progression) in the diseased bowel was noted and by correlating the two modes of examinations the significance of the changes was brought out. The exhibit showed the appearance and correlation of these changes in representative cases.

Second—St. Luke's Hospital, Milwaukee, "Newborn Surgical Emergencies."
Third—C. J. Levinson, M.D., Milwaukee, "Culdoscopy for Diagnosis."

LARGE HOSPITALS

First—Wood VA Center, Wood, "Renal-Retinal Pathology."
Second—Evangelical Deaconess Hospital, Milwaukee, "Lymphoid Cell Variations in the Peripheral Blood."
Third—St. Joseph's Hospital, Milwaukee, "Correlation of X-Ray and Sigmoidoscopic Findings in Ulcerative Colitis."

CES Foundation

GRANTS

Accepted a $3,000 grant from a Wisconsin foundation to support a health education project in Menominee County, with matching funds to be provided by the CES Foundation.

AWARDS

To Fredrick J. Stare, M.D., Boston, for presentation of the first Conrad A. Elvehjem Memorial Lecture, and Ivan Baranofsky, M.D., San Diego, for presentation of the fifth William Beaumont Memorial Lecture.

ELECTIONS

Reelected officers of the Foundation were:
President: W. D. Stovall, M.D., Madison
Vice-president: A. J. McCarey, M.D., Green Bay
Treasurer: G. J. Schulz, M.D., Union Grove
Secretary: Mr. C. H. Crownhart, Madison

Father Edward J. O'Donnell, S.J., chancellor of Marquette University, receives a check from the American Medical Association and Research Foundation (AMA–ERF) for the School of Medicine, presented by Dr. Edward R. Annis, Miami, Florida, president-elect of the AMA, at the annual dinner. Doctor Annis, an alumnus of Marquette, was the featured speaker at the dinner.

Father O'Donnell also received the Presidential Citation of the State Medical Society "in recognition of a distinguished career as president of Marquette University, for his attainments in the fields of education and administration, and for his insight, understanding and leadership in the face of the complexities of medical education during a period of rapidly expanding medical sciences," from Dr. N. A. Hill, Madison.

PRESIDENT EGAN reports:

On May 6 the House of Delegates received the Booz–Allen–Hamilton Survey without recommendation and moved appointment of a seven-man committee to survey and make appropriate recommendations in the form of resolutions to the House at the next meeting.

On May 10 I sent out a letter to 266 officers, delegates and other members of the State Medical Society. It asked for suggested names to make up a pool of prospects for consideration for appointment, keeping in mind that the assignment calls for attention, interest, work, and cooperative, fair, objective, prudent and diligent attitude.

The response was immediate and very helpful. There were 211 names submitted. The list was considered separately by Speaker Callan, Vice-Speaker Carey, Council Chairman Fox, and myself who were designated to select the implementation committee.

The committee chosen consists of Drs. Joseph C. Griffith, R. P. Sproule, and Gamber F. Tegtmeyer, of Milwaukee; C. J. Picard, Superior; L. W. Schrank, Waupun; Paul B. Mason, Sheboygan; and J. H. Houghton, Wisconsin Dells.

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin.

Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills.

In any event, all contributions to the Foundation are deductible for income tax purposes.

Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.

WOMAN'S AUXILIARY

Results of the Art Show, sponsored by the Woman's Auxiliary to the State Medical Society, during the 1963 Annual Meeting, in Milwaukee on May 6, 7, 8, and 9.

Oils

First Prize—Mrs. Stanley Berlow, 820 W. Bradley Road, Milwaukee for "Emerging Forms"
Second Place—Mrs. Marvin Wells, 7443 N. Beach Drive, Milwaukee for "Gambit"
Third Place—Dr. William Hovis, 304 E. Bradley Road, Milwaukee for "Cascade"
Honorable Mention—Mrs. Charles Doehlert, 4910 Fond du Lac, Madison for "The Heron"; Dr. L. G. Kilpatrick, 2707 Marshall Court, Madison for "Landscape"; Dr. Milton Gutglass, 7426 N. Crossway Road, Milwaukee for "Still Life"

Watercolors

First Prize—Dr. Milton Gutglass, 7426 N. Crossway Road, Milwaukee for "The Trunk"
Second Place—Mrs. Richard Byrne, 1207 E. Fairy Chasm Road, Milwaukee for "Spring Thaw"
Third Place—Dr. L. H. Hogan, 5041 LaCrosse Lane, Madison for "Mesa Verde"
Honorable Mention—Dr. C. F. McDonald, 2602 E. Oklahoma, Milwaukee for "St. Germain"; Mrs. Kinge Hara, 1930 Menomonee River Parkway, Milwaukee for "A Street in New York"; Mrs. A. R. Curreri, 3636 Lake Mendota Drive, Madison for "The Rugged Ones"

Sculpture

Award—Mrs. George Oosterhous, 121 Standish Court, Madison for "American Girl"

Popularity Award

"St. Germain" by Dr. C. F. McDonald, 2602 E. Oklahoma, Milwaukee, Watercolor
"Untitled" by Dr. Robert Haukohl, 17865 Greenbrier Drive, Brookfield, Oil
"American Child" by Mrs. George Oosterhous, 121 Standish Court, Madison, Sculpture

* * *

Judge—Mr. Tracy Atkinson, director, Milwaukee Art Center
Chairmen—Dr. and Mrs. Harry Foerster, Jr., Milwaukee
Co-Chairmen—Dr. and Mrs. William Hovis, Jr., Milwaukee

New Auxiliary Officers

President: Mrs. W. D. James, Oconomowoc
President-elect: Mrs. J. J. Satory, La Crosse.
Vice-president: Mrs. E. M. Burns, Madison.
Recording secretary: Mrs. J. W. Sargent, Milwaukee.
Corresponding secretary: Mrs. L. J. Driscoll, Oconomowoc.
Treasurer: Mrs. D. A. Hammes, Green Bay.
Immediate Past President: Mrs. E. M. Dessloch, Prairie du Chien.

The State Medical Society of Wisconsin

ORGANIZED 1841

W. J. EGAN, Milwaukee, President
W. P. CURRAN, Antigo, President-elect
R. E. CALLAN, Milwaukee, Speaker
H. W. CAREY, Lancaster, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

J. C. FOX, La Crosse, Chairman
J. M. BELL, Marinette, Vice-chairman

Term Expires 1966

First District:
W. D. James.....Oconomowoc

Second District:
G. J. Schulz.....Union Grove

Term Expires 1965

Third District:
M. D. Davis.....Milton

Term Expires 1964

E. J. Nordby.....Madison

Term Expires 1966

C. W. Stoops.....Madison

Term Expires 1964

Fourth District:
E. M. Dessloch.....Prairie du Chien

Term Expires 1964

Fifth District:
P. B. Blanchard.....Cedarburg

Sixth District:
H. J. Kief.....Fond du Lac

Term Expires 1965

George Nadeau.....Green Bay

Seventh District:
J. C. Fox.....La Crosse
(Chairman)

Eighth District:
J. M. Bell.....Marinette
(Vice-chairman)

Ninth District:
R. W. Mason.....Marshfield

Tenth District:
R. C. Frank.....Eau Claire

Term Expires 1966

Eleventh District:
V. E. Ekblad.....Superior

Twelfth District:
L. J. Van Hecke.....Milwaukee
W. J. Houghton.....Milwaukee

Term Expires 1964

D. M. Willson.....Milwaukee

Term Expires 1965

S. L. Chojnacki.....Milwaukee
S. W. Hollenbeck.....Milwaukee

Thirteenth District:
Marvin Wright.....Rhinelander

Term Expires 1964

N. A. Hill.....Madison
(Past President)

Delegates to American Medical Association
(Terms end on December 31 of year indicated)

L. O. Simenstad, Osceola, 1964
E. L. Bernhart, Milwaukee, 1964
R. E. Galasinski, Milwaukee, 1963
A. A. Quisling, Madison, 1963

Alternates

John M. Bell, Marinette, 1964
C. J. Picard, Superior, 1964
George Collentine, Jr., Milwaukee, 1963
W. B. Hildebrand, Menasha, 1963

List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	Wm. Smiles 522 W. 2nd St., Ashland	C. A. Grand 206–6th Ave., W., Ashland	
Barron–Washburn–Sawyer–Burnett	D. G. MacMillan Barron	J. K. Hoyer 40 W. Newton, Rice Lake	Second Tuesday 7:30 p.m.
Brown	John E. Dettman 519 S. Monroe Green Bay	Frank Urban Rm. 308, City Hall, Green Bay	Second Thursday*
Calumet	K. R. Humke Chilton	R. E. Knauf Chilton	
Chippewa	Charles A. Kemper 727 Maple, Chippewa Falls	C. T. Bowe Cadott	Second Tuesday
Clark	E. Dolf Pfefferkorn Colby	Bahri Gungor Loyal	
Columbia–Marquette–Adams	R. T. Cooney 310 W. Conant St., Portage	J. W. Pavelsek, Jr. 122½ E. Cook St., Portage	Every Third Month 7:00 p.m.
Crawford	M. S. Garrity 610 East Taylor St., Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	R. N. Allin 1313 Fish Hatchery Rd. Madison	Gordon Davenport 110 E. Main, Madison	Second Tuesday**
Dodge	Fred A. Karsten 514 E. Lake St., Horicon	Norman Erickson 302 N. Spring St., Beaver Dam	Last Thursday*
Door–Kewaunee	Patricia Lanier Kewaunee	E. W. Wits 213 Ellis, Kewaunee	
Douglas	L. R. Rosin 2231 E. 5th St., Superior	Enzo Krahl 324 Board of Trade Bldg. Superior	First Wednesday* Hotel Superior
Eau Claire–Dunn–Pepin	R. R. Richards 605 Walker Ave., Eau Claire	W. H. Walter 131 S. Barstow St., Eau Claire	Last Monday
Fond du Lac	C. M. Flannagan 80 Sheboygan St. Fond du Lac	W G. Kendell 92 E. Division St., Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley, Wabeno	D. V. Moffet, Crandon	
Grant	C. L. Steidinger Platteville	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	W. J. Fencil 921 16th Ave., Monroe	B. H. Brunkow 921 16th Ave., Monroe	
Green Lake–Waushara	Grant Stone 124 N. Wisconsin, Berlin	L. J. Seward 147 N. State St., Berlin	Last Thursday, every other month starting in Jan.

* Except June, July and August. ** Except July and August

List of Officers and Scheduled Meetings of County Medical Societies (Continued)

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	David Downs Dodgeville	E. J. Hohler Mineral Point	First Thursday following first Monday
Jefferson	E. A. Miller 133 Riverlawn Ave. Watertown	J. S. Garman 144 W. Madison, Waterloo	Third Thursday°
Juneau	J. H. Vedner Mauston	Jack Strong Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	J. J. Lutz 1202 60th St., Kenosha	G. F. Armstrong 6530 Sheridan Rd., Kenosha	First Thursday° Elks Club
La Crosse	George Skemp 312 State St., La Crosse	Ruth Dalton St. Francis Hosp., La Crosse	Third Monday
Lafayette	R. E. Hunter Argyle	L. L. Olson Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Fifth, Antigo	Earl J. Roth Professional Bldg., Antigo	First Monday
Lincoln	J. D. Millenhah 121 S. Mill St., Merrill	E. O. Ravn, Jr. 1802 9th St., Merrill	
Manitowoc	R. G. Yost 918 Washington St. Manitowoc	S. L. Kaner 1421 17th St., Two Rivers	Last Thursday
Marathon	R. H. Brodhead Box 838, Wausau	George Kordiyak 126 Grand Ave., Wausau	
Marinette–Florence	R. J. Maginn 1232 Mill St., Niagara	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	R. A. Frisch 425 E. Wisconsin Ave., Milwaukee	W. C. Curtis 10425 W. North Ave. Wauwatosa Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milw.	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	G. R. Sandgren Suring	H. A. Aageson 1113 Main St., Oconto	
Oneida–Vilas	Allen Johnson Rhinelander	Marvin Wright 1020 Kabel Ave., Rhinelander	Monthly
Outagamie	F. M. Hauch 722 W. Lawrence St., Appleton	Wm. Chandler 402 W. Wisconsin, Appleton	Third Thursday° Elks Club
Ozaukee	R. F. Henkle 549 W. Grand Ave., Port Washington	P. W. Wallestad 502 W. Jefferson, Port Washington	
Pierce–St. Croix	H. J. Laney Prescott	P. H. Gutzler River Falls	Third Tuesday
Polk	Donald Fink St. Croix Falls	Lloyd L. Olson St. Croix Falls	Third Thursday 7:00 p.m.
Portage	Walter Gramowski 319½ W. Main St. Stevens Point	Albert Kohn 313 N. Fremont Stevens Point	
Price–Taylor	J. D. Leahy Park Falls	J. L. Murphy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	W. H. Williamson 1101 Grand Ave., Racine	L. E. Jones 431 15th St., Racine Mr. G. N. Geraghty 600 Villa Street, Racine Exec. Sec.	Third Thursday
Richland	R. W. Edwards 118 West Mill St. Richland Center	L. M. Pippin 323 South Central Ave., Richland Center	First Thursday Richland Hospital
Rock	R. M. Baldwin 419 W. Pleasant St., Beloit	W. A. Scholten, Jr. 1146 Grant, Beloit	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	H. P. Baker Wonewoc	R. G. Knight 244 E. Main St., Reedsburg	Second Tuesday°
Shawano	H. F. Laufenberg Shawano	A. J. Sebesta Shawano	Third Wednesday
Sheboygan	Arthur C. Tompsett 920 Huron Ave., Sheboygan	J. F. Kovacic 708 St. Claire Ave., Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	Richard L. Holder 221 Main St., Black River Falls	J. H. Noble 1109 Harrison Black River Falls	Fourth Tuesday
Vernon	Roy B. Balder, Jr. Elroy	C. A. Ender Viroqua	Last Wednesday
Walworth	Henry Mol Elkhorn	Rocco S. Galgano 610 Walworth, Delavan	Second Thursday°
Washington	James Albrecht 118 E. Main St., Jackson	W. E. Scheuenemann 128 N. Main, West Bend	Fourth Thursday
Waukesha	Robert Feulner 630 Oxford Rd., Waukesha	W. E. Rosenkranz 720 N. Rochester, Mukwonago	First Wednesday
Waupaca	George Dernbach New London	Lloyd P. Maasch Weyauwega	
Winnebago	R. H. Quade 116 So. Commercial St., Neenah	E. J. Zmolek 302 N. Main St., Oshkosh	First Thursday
Wood	F. John Gouze 650 S. Central Ave., Marshfield	John W. Rupel 650 S. Central, Marshfield	Four times a year

° Except June, July and August. °° Except July and August

the wisconsin medical journal

VOLUME 62/NUMBER 7 JULY 1963

MARQUETTE SPECIAL

A Half Century of Service

By JOHN S. HIRSCHBOECK, M. D.

Dean, Morquette University School of Medicine

Milwoukee, Wisconsin

■ AN ANNIVERSARY celebration is an occasion for reflection upon the past and what the future may bring. In looking back upon fifty years of growth and development of the Marquette University School of Medicine, one sees an example of what has happened in most American medical schools which survived and were reformed as a consequence of the alarming criticism of Abraham Flexner in 1910. In the words of John Bowers:

> "Abraham Flexner, more than any other man, was the architect of modern medical education in the United States. Would we stand among those in the forefront in world health today if it had not been for Flexner? By his leadership in advancing medical education, Flexner contributed to the health of millions of citizens whose lives have been saved by medical research and capable doctors." (Journal of Medical Education, Volume 35, 1960)

It was indeed fortunate that the Milwaukee Medical College and the Wisconsin College of Physicians and Surgeons joined with Marquette University to establish the new medical school. Without the dogged determination of Father C. B. Moulinier, Dr. Louis F. Jermain, and a handful of spirited physicians, Wisconsin would have been without a complete medical school for many years, and a generation of physicians would never have come to be. The State of Wisconsin will forever be indebted to these men for providing a great social need at so much personal sacrifice and with so little financial assistance. Following their example, the faculty and administration during the past fifty years have created a medical school of which all of us can be proud.

The Marquette University School of Medicine belongs to Wisconsin, and its future prosperity will depend more than ever upon the good will and support of our citizens and the medical profession. The next half century will no doubt provide problems and challenges of unimaginable magnitude and complexity for the medical schools and the medical profession. The physicians of Wisconsin, in the spirit of the Hippocratic Ethic which places responsibility on the medical profession for the education of those who will follow us, have given their moral and financial support to our two medical schools. They will need this support more than ever if the profession is to maintain this influence upon medical education. It is a great responsibility, second only to providing medical care for our fellow men. Whatever satisfaction we now enjoy after fifty years can only whet the appetite for future accomplishment. Our life has only just begun.

MARQUETTE SPECIAL

A Salute to 50 Years of Progress

By EDWARD R. ANNIS, M. D. Miami, Florida

President, American Medical Association

■ IT IS OF particular significance to me to be able to participate in this 50th anniversary salute to the Marquette University School of Medicine.

We both were born in the same year—1913.

Additionally, of all of the honors I have achieved in the field of medicine, probably the most important is the sheepskin hanging on the wall of my office attesting that my degree of Doctor of Medicine was awarded to me by Marquette in 1938.

The intervening 25 years have seen probably the greatest strides in the advancement of medical progress the world has ever known, and Marquette and its graduates have contributed importantly to that progress.

Because of that progress, four and one-half million Americans are alive today who would be dead if the mortality rate of 25 years ago still prevailed. And these four and one-half million Americans earned almost 10½ billion dollars in 1960.

At least 80 per cent of the drugs commonly prescribed today were unknown just 10 years ago. And the United States has made more important drug discoveries in the last 20 years than all the rest of the world combined, or seven times as many as the next leading country.

There now is a record number of hospital beds in this country—one million, 670 thousand—an increase of more than a quarter-million beds since 1948. The average stay in a hospital, due to medical progress, is at its lowest in history, averaging 7.5 days.

During the past year, infant mortality rates declined to the lowest in United States history—25.3 deaths per 1,000 births.

A record number of 7,168 new physicians graduated from U. S. medical schools this year, and a record number of 31,078 students are enrolled in medical schools.

In the past 13 years, this nation has built 763 new hospitals, increasing the total number of hospitals to almost 7,000.

An estimated 140 million Americans were protected by some form of voluntary health insurance in 1962. That's 75 per cent of the population and the number is expanding rapidly. More than three million Americans added voluntary health insurance to their coverage during the year.

By way of illustrating this remarkable growth in voluntary health insurance, in 1950—just 12½ years ago—only 76.6 million American people had this type of coverage.

Today, the American people are getting more for their health care dollar than at any time in history. They spend only six cents out of every dollar on health care. They spend almost as much on liquor and tobacco, and three times as much on recreation and travel.

Under free medicine, America has become the acknowledged leader of medical science in the world. Whereas years ago, American physicians travelled to all corners of the globe to acquire new skills and knowledge in the field of medicine, today the reverse is true. Doctors from all parts of the world are clamoring to come to America to add to their knowledge.

Typical of the progress that American medicine has made is the fact that today, two-thirds of those who now are admitted to mental hospitals are discharged during the first year. But 30 years ago, a patient entering a

mental hospital could expect to remain there up to 30 years, or even the rest of his life.

Death rates of acute rheumatic fever and influenza are down about 85 per cent since 1944.

Today, one out of every three cancer patients survives, whereas only one in seven survived in 1937.

Only 40 years ago, one in every four subject to a major operation died. Today, only one in 100 dies, and operations are performed that were impossible only a few years ago.

Yes, the list of milestones that has been passed by free medicine in America in the last half century is endless. All medicine has had a hand in this, to be sure.

But Marquette's School of Medicine has served importantly. Its contributions have been great.

Marquette University and its School of Medicine have given us young men of high purpose, character and dignity who have served, and continue to serve, mankind in the noblest and highest traditions of their profession.

I am happy to join in this salute to its 50th year of progress, and to wish for it continued progress.

Marquette University School of Medicine

THE FIRST FIFTY YEARS

By WALTER ZEIT, Ph. D., *Associate Dean and Chairman, Department of Anatomy, Milwaukee, Wisconsin*

■ MARQUETTE University School of Medicine had its origin in the ruins of two Milwaukee medical schools which had been in operation for two decades. The Milwaukee Medical College and the Wisconsin College of Physicians and Surgeons were proprietary medical schools typical of the times. The famous Flexner Report which started the revolution in medical education in this country fifty years ago gave both schools a very poor rating. The student bodies of both schools grew restless and demanded improvements. When it became apparent that improvements would not be made, the entire student body of the Milwaukee Medical College, located on the corner of North Ninth Street and West Wells Street, withdrew and marched in a body to the Wisconsin College of Physicians and Surgeons, located at North Fourth Street and West Reservoir Avenue, and enrolled in that school. The Milwaukee Medical College practically ceased to exist because it had no student enrollment.

The Wisconsin College of Physicians and Surgeons was financially insolvent and could not offer prospects of academic improvement. Prominent members of the medical profession in Milwaukee, under the leadership of Dr. Louis F. Jermain, approached Marquette University and promised to support efforts to form a university oriented medical school. In 1913 Marquette University purchased outright the building and equipment of the Wisconsin College of Physicians and Surgeons and leased the building and equipment of the Milwaukee Medical College. Marquette University School of Medicine was now organized. Dr. Louis F. Jermain became the Dean, and the Reverend C. B. Moulinier, S. J. was appointed the Regent.

Efforts were immediately begun to improve the academic condition of the School in accordance with the recommendations of the Council on Medical Education and Hospitals of the American Medical Association. The first two full-time faculty members were appointed. Dr. Henry C. Tracy was appointed Professor of Anatomy and Dr. Albert F. Boretti, Professor of Pathology and Bacteriology. Within a year, three additional full-time teachers were added. Dr. Chester J. Farmer became Professor of Biochemistry, Dr. John Van de Erve, Professor of Physiology and Pharmacology and Dr. Walter E. Sullivan, Professor of Biology and Histology. One full year of pre-medical collegiate work was established as a minimum requirement for admission. Within another year, entrance requirements were raised to two years of collegiate work. In 1915 the School was rated Class A by the Council on Medical Education and Hospitals of the A.M.A.

Clinical teaching was conducted at St. Joseph's Hospital, across the street from the Medical School building and at the Milwaukee County Hospital. There was no formal agreement of affiliation between

Fig. 1—Marquette University School of Medicine from 1913 to 1932. Formerly the Wisconsin College of Physicions ond Surgeons.

the hospitals and the Medical School. The Medical School also conducted two free dispensaries for outpatient teaching. Both were remnants of the two old medical schools. All clinical teaching was done by volunteer members of the Faculty who received no salary.

The new Medical School boasted of a medical library of 3,000 volumes and subscriptions to 42 journals. It was also claimed that 16 additional journals were received regularly by donation from subscribers in Milwaukee.

Faculty build-up in the basic science departments continued. In the fall of 1914, Mr. Ernest H. Wood became an assistant in the Department of Biochemistry and Dr. Edward F. Barta joined the faculty in the Department of Pathology. Dr. A. H. Levings was Professor of Surgery, Dr. Louis F. Jermain, Professor of Medicine and Dr. R. W. Roethke, Professor of Obstetrics and Gynecology. Tuition in the Medical School was $170 per year and the highest priced microscope sold for less than $100.

In 1915 Dr. I. E. Wallin became an instructor in Histology and Dr. Clarence Turner an instructor in Biology. There was no Department of Biology in the College of Liberal Arts, therefore, Biology was taught to premedical students in the Department of Anatomy of the Medical School. Dr. F. A. McJunkin, replaced Dr. Albert F. Boretti as Director of the Department of Pathology and had the title of Professor of Pathology, Bacteriology and Public Health. Dr. Daniel Hopkinson became Assistant Professor of Pathology. At this time Dr. B. F. McGrath was appointed to the full-time position of Professor of Experimental and Junior Surgery. In 1917 Mr. Leo C. Massopust became full-time artist to the Department of Anatomy. Dr. J. L. Yates replaced Dr. "Ham" Levings as Director of the Department of Surgery and the title of Doctor McGrath was changed to Professor of the Principles of Surgery and Director of the Surgical Laboratories.

A significant event of 1917 was the announcement of reorganization of the Medical School. Marquette University delegated to a Board of Trustees, complete government and management of the Medical School, both financial and educational. The Constitution and Bylaws of the Board of Trustees called for the establishment of an Administrative Board, invested with full authority to conduct and operate the Medical School "together with the executive and financial administration incident thereto." The Dean was to be nominated by the Administrative Board and appointed by the Board of Trustees for a period of three years.

This was indeed a curious situation, not to be found in any other American university. Marquette University owned the Medical School and made up its financial deficits but could exercise only remote control. The reason for this reorganization became apparent when the announcement was made that the Carnegie Corporation had offered the Medical School one-third of a million dollars toward an endowment of one million, on condition that the University raise the other two-thirds. The reorganization was a device to assure the donors that no funds would be diverted to University purposes other than the Medical School. The campaign to secure the two-thirds of one million dollars through public subscription was successful and by 1919 the Medical School had an endowment of one million dollars.

It should be noted here that the Medical School is still a separate financial corporation from the rest of Marquette University. We shall see that as the years passed, control of the operation of the Medical School gradually returned to the authorities of the University. The Medical School is now an intimate member of the University academic community.

Constant improvements were made by remodeling of physical facilities and additions to the Faculty. In 1918 Mr. Peter M. Sinsel was appointed Business Manager of the Medical School and Dr. Joseph C. Bock succeeded Chester J. Farmer as Professor and Director of the Department of Biochemistry.

In 1918 and 1919 Marquette University School of Medicine was rocked by a controversy which was followed from day to day in the Milwaukee daily papers. This centered around a difference of opinion on certain questions of professional procedures in obstetrics between the Jesuit Fathers of the University and certain members of the Medical School Faculty. Obviously, in maintaining their standards of ethics, the authorities of the University could not

compromise. The conflict was brought to an end by the resignation of a number of the most prominent members of the Medical School Faculty. These were men who had excellent professional reputations which extended far beyond the limits of Milwaukee. Dire predictions were made that the Medical School could not survive the departure of these leaders in the profession.

Through these events the imperturbable Doctor Jermain, Dean of the Medical School stood out as a solid rock. By patient manipulation he induced others to take over the vacated key positions and the School survived. Dr. W. C. F. Witte became Professor and Director of the Department of Surgery. Dr. Otto F. Kampmeier was appointed Associate Professor of Anatomy and acting Director of the Department. Dr. Benjamin H. Schlomovitz became Director of the Department of Physiology and Pharmacology; Dr. Albert J. Bruecken, Professor and Director of the Department of Bacteriology and Hygiene; and Dr. Maurice L. Henderson, Director of the Department of Obstetrics and Gynecology.

Behind the scenes the controversy was undoubtedly a power struggle between the certain members of the Faculty and the President of the University. Some members, trying to use the Administrative Board, could recognize no limit to authority "incident to the executive and financial administration of the School." It is significant that the community leaders who made up the Board of Trustees of the Medical School, remained loyal to the University.

The uncertainties of the growing years caused some turnover in the small full-time basic science faculty. Dean Jermain carried on a continuous stuggle to increase and strengthen the Faculty and to improve physical facilities. In 1920 the Reverend Hugh B. MacMahon, S. J., was appointed Regent. Dr. Eben J. Carey, became Professor of Anatomy and Director of the Department. Dr. P. F. Swindle was appointed Associate Professor in the Department of Physiology and Pharmacology. The following year Dr. Edward L. Miloslavich, of Vienna, was brought to this country to become Professor and Director of the Department of Pathology and Bacteriology.

In 1920, the satisfactory completion of one year of internship in an approved hospital was added as a requirement for the M.D. degree. A number of medical schools added this "fifth year" requirement for graduation at this time. Most medical educators did not consider the education of the physician completed until a year of internship had been added to the students experience. Many states did not require internship as a qualification for license to practice. By adding the fifth year, the Medical School could be certain that none of its graduates would attempt to practice medicine without the experience of a year of internship.

In 1922, the free dispensary operated by the Medical School was moved to the old Trinity Hospital at North Ninth Street and West Wells. This was the building of the old Milwaukee Medical College. Trinity Hospital now became The Marquette University Hospital.

The Dispensary had been housed in a building adjacent to the Medical School. It was moved to make room for expansion of basic science facilities. The Dispensary building was remodeled for the Medical Library which sorely needed space. Additional space for expansion was obtained by moving the Department of Physiology and Pharmacology from the first floor of the Medical School to an old store building one block away. This building, located on the corner of Fourth and Hormon Streets, consisted of a large street level room, the student laboratory, formerly a butcher shop, a basement and second floor rooms which had been living quarters. It offered very meager quarters for the Department, but to the students of those years it was always known as the "Institute of Physiology." It was a dismal place indeed.

A significant event in 1922 was the addition of almost one million dollars to the original endowment of one million, through the bequest of Mrs. Harriet L. Cramer. Mrs. Cramer was the widow of W. E. Cramer who was the publisher of the *Evening Wisconsin*, a Milwaukee daily paper. After the death of Mr. Cramer, Mrs. Cramer, an energetic woman, carried on as publisher for a number of years.

In the next few years additional full-time faculty members were added to all the basic science departments. Dr. Frederick A. Stratton became Professor and Director of the Department of Surgery. Dr. Harry Beckman joined the Faculty in 1923 to become Professor and Director of the Department of Pharmacology the following year. The Reverend Patrick A. Mullins, S. J., succeeded Father MacMahon as Regent.

Another minor reorganization occurred in 1922. The old Administrative Board, appointed by the Board of Trustees, was replaced by an Executive Faculty, appointed by the President of the University, and the Dean was appointed by the President instead of by recommendation of the Administrative Board. This resulted in closer integration with the rest of the University.

Fig. 2—Marquette University Hospital and Out-patient Clinic 1922 to 1929. Formerly Trinity Hospital and the Milwaukee Medical College.

Dr. Louis F. Jermain, the first Dean of the Medical School, became Dean Emeritus in 1926. Dr. Eben J. Carey had been carrying part of the responsibility of the Dean's Office, having been named Dean of Students in 1920. Doctor Carey was appointed Acting Dean of the Faculty. Doctor Jermain retained his position as Clinical Professor of Medicine and Director of the Department. In 1927 the Reverend Anthony F. Berens, S. J., became the Regent. Father Berens was destined to be with the Medical School for many years and became an important figure in the development of the School.

Dr. Bernard F. McGrath had occupied a unique position in the Medical School. As Professor of the Principles of Surgery, he gave a series of didactic lectures on surgery to the third year students. As Director of the Surgical Laboratories, he gave a course in operative surgery on dogs, training students in operative procedures and operating room discipline. In 1928 he was made Dean of the School, a position he filled for five years. Students and Faculty of those years remember him as a strange man. He was always stern and seemed to feel few kindly moments towards medical students. He was strictly a swivel-chair dean. He seldom ventured out of his office and none can recall that he ever visited any of the hospitals or institutions in which clinical teaching was being conducted. Almost all communication with him by students or faculty had to be in writing. Tape-recording devices were not yet available, but most unimportant conversations were recorded in shorthand by an ever-present secretary. The Bulletins of those years contain many pages of intricate schedules which he devised for the rotation of students through various assignments.

It is fortunate indeed, that during these years, the clinical departments had devoted volunteer teachers who carried on in spite of the lack of guidance from the Dean's Office. In 1928 Dr. Francis D. Murphy was appointed Professor of Medicine and Director of the Department. He had also become Medical Director of the Milwaukee County Hospital and Dr. Joseph M. King its Surgical Director. With the help of many others, these sturdy men guided the clinical teaching of the third and four years, although an adequate formal agreement between the Medical School and the Milwaukee County Institutions was lacking.

In 1929 a landmark in medical education in Milwaukee passed from the scene. The Marquette University Hospital was closed. The building located at Ninth and Wells Streets had formerly been Trinity Hospital and the home of the Milwaukee Medical College. In 1907 Marquette University had formed a loose affiliation with this School. Degrees in Medicine were granted by the University but the University had no control whatever in the operation of the School. The Milwaukee Medical College continued to be a proprietary school until it was absorbed into the Marquette University School of Medicine in 1913.

The same year also saw the departure from the Faculty of Dr. Edward L. Miloslavich, Professor and Director of the Department of Pathology and Bacteriology. He was replaced by Dr. Marcos Fernan-Nunez. For a few years after his arrival from Vienna, Doctor Miloslavich built up the Department and devoted himself to teaching. His interests strayed, however, to acquiring appointments as pathologist to hospitals and medico-legal work for insurance companies. He also attempted to create a reputation for himself as a criminologist and never missed an opportunity for publicity. Soon his responsibilities at the Medical School were turned over to subordinates and his departure was by mutual agreement. A few years later, when his services were no longer in demand in Milwaukee, he returned to his native Croatia.

Fig. 3—The Horriet L. Cromer Memorial Building of Marquette University School of Medicine facing on North Fifteenth Street.

For years there had been much discussion and wishful thinking about a new building for the Medical School. While all the talking was going on, the Regent, Father Berens, quietly and persistently, devoted his energy to developing actual plans. In the fall of 1931, without much fan-fare, construction was begun. It proved to be an opportune time. It was one of the worst years of the depression. Contractors were glad to have their equipment busy and their men employed. The building was completed in the summer of 1932 and the first classes held that fall. It consisted of a basement, four floors and a penthouse for animal quarters, fronting for 260 feet on North Fifteenth Street with three wings extending back for 180 feet. The total cost was $435,000, completely equipped. Five years later it would have cost three quarters of a million to duplicate, and ten years later at least one million. The new building made it possible to increase the enrollment of freshmen from 75 to 100. In memory of Mrs. Cramer, it was named the Harriet L. Cramer Memorial Building.

The depression years, up to the beginning of World War II, were relatively uneventful. The National Youth Administration helped a number of students over the financial difficulties of a medical education. In 1933 Dr. Eben J. Carey became Dean, and

in 1935 Dr. Armand J. Quick joined the Faculty in the Department of Pharmacology. The chair in the Department of Obstetrics and Gynecology had been vacant for over a year when Dr. Roland S. Cron was appointed Professor and Director in 1938. In 1939 the requirement for admission to the Medical School was raised to a minimum of three years of premedical liberal arts collegiate work.

The *Marquette Medical Review* was founded in 1936 by a group of enterprising students. This medical quarterly has now been published for over twenty-five years. It is managed and edited entirely by students. Each year senior students who have served on the staff of the *Review* for three years are awarded a scroll and a gold key.

World War II caused many changes. On July 6, 1942, all teaching programs in the Medical School went on an accelerated program. Vacations were few and short. There were several instances when one academic year ended on a Friday and the next one started the following Monday. Medical students were first given provisional commissions in the Army or Navy in order to prevent the draft boards from removing them from school. Then the Army Student Training Corps (ASTP) and the Navy V 12 program were organized and all of the students were enlisted and placed in uniform. Army and Navy officers were in charge and a rigid daily routine established.

The academic year 1942–1943 was the last of the five-year program. The degree Doctor of Medicine was granted at the end of the fourth or senior year because most states required the completion of an approved internship for license to practice.

In 1944 Dr. Joseph C. Bock became Emeritus Professor of Biochemistry. Dr. Armand J. Quick was transferred from the Department of Pharmacology to become Professor of Biochemistry and Chairman of the Department. In the same year Dr. Marcos Fernan-Nunez, Chairman of the Department of Pathology and Bacteriology, departed and was succeeded by Dr. John Grill. Doctor Nunez will always be remembered by the students of those years for the tall tales of his experiences in South American jungles and for his "Sanhedrin" method of conducting examinations. Dr. John Grill was not destined to be Professor of Pathology long. In less than one year after his appointment he died suddenly. Doctor Grill had been brought from Vienna to the Medical School in 1922 by Doctor Miloslavich. He was a kind and understanding man and a lucid teacher. He was always held in high esteem by his colleagues and students. Dr. W. A. D. Anderson became Professor of Pathology and Bacteriology in 1945.

The freshman class which enrolled on November 12, 1946, was the last to enter on the accelerated program of the war years. By September 1947, regular academic years were reestablished and three-month summer vacations were restored.

In January 1946, an affiliation was formed between the Medical School and the Veterans Administration Hospital at Wood, Wisconsin. The hospital is about a ten-minute drive from the School and has a capacity of over 1,200 beds. The need to improve facilities and patient care in V. A. hospitals across the country had been recognized. It was anticipated that large numbers of World War II veterans would soon need care. The affiliation provided for the formation of a Dean's Committee composed of leaders in the clinical specialties of the Faculty. They were given the responsibility of developing residency training programs, recruiting competent specialists as teachers of the residents, and supervising and directing patient care. Soon undergraduate medical students were assigned to the Wood V. A. Hospital and it became essentially a University Hospital. As the years have passed, the Wood V. A. Hospital has become thoroughly integrated with the Medical School. Full-time members of the professional staff employed by the V. A. at the Hospital are members of the Faculty, and many members of the Medical School Faculty visit the hospital contributing to patient care and the teaching and research programs.

In June of 1947, Dr. Eben J. Carey, Dean of the Medical School and Chairman of the Department of Anatomy, died after a short illness. Doctor Carey came to the Medical School in 1920 and had been Dean since 1933. All who knew him recall that he was a man of seemingly unlimited energy. Many of his interests were outside of the Medical School. For many years he was Chairman of the Executive Trustees of the Phi Chi Medical Fraternity and editor of its quarterly. He was active in County and State Medical Societies and in the A.M.A. He promoted health exhibits for the Wisconsin Medical Society to carry the message of medical science and health to the public. He was in charge of medical science and health exhibits at the Century of Progress, World's Fair in Chicago, in 1932 and 1933. For years he was director of medical science exhibits at the Museum of Science and Industry in Chicago. As Dean, Doctor Carey devoted most of his efforts to the development of the basic science departments. At times this made him unwary of the needs of the clinical departments. It must be recognized again that through all these years, a sincere, devoted and loyal clinical faculty, who received no compensation, maintained the teaching programs and the standard of good clinical teaching.

In 1947, Dr. Walter Zeit became Professor of Anatomy and Chairman of the Department. Dr. John S. Hirschboeck was appointed Dean of the Medical School. At the time of this writing, Dr. Hirschboeck has been Dean of the Medical School for fifteen years. These years have been the most fruitful in the growth and development of the Medical School. Doctor Hirschboeck recognized the need for the development of a full-time clinical faculty, particularly in key teaching and administrative positions. At the same time, constant improvements were made in the basic sciences.

In 1949, the courses in Bacteriology were separated from the Department of Pathology, and the Department of Microbiology and Immunology was

formed. Dr. A. L. Kappus, who had joined the faculty in 1947, was appointed Professor and Chairman of the Department. In the same year the Department of Medical Technology was formed. For many years training programs in medical technology had been offered by various departments of Marquette University. It was now established as a program leading to the Bachelor of Science degree under the direct supervision of the Department of Pathology of the Medical School. In 1949 Dr. Edward A. Bachhuber was appointed Assistant Dean with an office at the Milwaukee County General Hospital. This was another step in strengthening the clinical teaching programs.

The next few years saw many changes and improvements. Dr. F. Herbert Haessler was appointed full-time Professor of Ophthalmology in 1949. Dr. Frederick Stratton became Emeritus Professor of Surgery and Dr. Carl W. Eberbach was appointed Professor and Chairman of the Department of Surgery in 1950. A Department of Physical Medicine and Rehabilitation was organized and Dr. Ray Piaskowski was appointed Professor and Chairman of the Department in 1951. Dr. James L. Smith succeeded Dr. P. F. Swindle as Professor of Physiology and Chairman of the Department of Physiology in 1951. Doctor Swindle had been Professor of Physiology for thirty years. He will always be remembered by his students for the unconventional Physiology he taught, referred to by them as "Swindology," but all will agree that his efforts were directed to teaching students how to observe and think for themselves. Dr. J. Cyril Peterson was appointed full-time Professor and Chairman of the Department of Pediatrics, thereby becoming Pediatrician-in-Chief to the Milwaukee Children's Hospital in 1952. A Department of Physical Therapy was organized and placed under supervision of the Department of Physical Medicine and Rehabilitation. A teaching program leading to the degree of Bachelor of Science in Physical Therapy was offered in 1952. Dr. Joseph F. Kuzma succeeded Dr. W. A. D. Anderson as Professor of Pathology and Chairman of the Department in 1952. Dr. Walter Zeit was appointed Assistant Dean in 1953.

In April 1948, hardly a year after the death of Dr. Eben J. Carey, his widow, Helene Carey, passed away. She left a bequest of $170,000 to the Medical School. In May 1954, the Eben J. Carey and Helene Carey Memorial Library Wing of the Medical School was dedicated. The cost of the new wing was almost one million dollars. Generous contributions from the alumni of the Medical School made construction possible. The new wing provided adequate modern space for the Medical-Dental Library which had now grown to almost 50,000 volumes and received 950 current medical periodicals. It should be recalled that in 1913, the Medical Library claimed to have 3,000 volumes and subscriptions to 42 medical periodicals. Space for the future expansion of the library was provided for years to come. The Milwaukee Academy of Medicine had recently given its collection to the Medical-Dental Library. For many years the Academy had maintained a medical library for its members and for the medical profession of the community. The Medical-Dental Library is now the central medical library and serves the physicians and hospitals of the greater Milwaukee area.

In 1955 Mrs. Edith Dernehl, the Librarian, retired and was succeeded by Miss Frances L. Beckwith. Mrs. Dernehl had been Librarian for 20 years and was responsible to a considerable extent for the growth and development of the library and planning of the new library wing. Students and faculty will always appreciate the policy established by Mrs. Dernehl of freedom to browse into every nook and cranny. They will also remember the miraculous way in which she could produce obscure items in a matter of moments. At this writing the Medical-Dental Library has grown to 53,000 volumes and receives 1,100 current periodicals. The library has an endowment of almost $30,000 from various donors.

In addition to providing adequate space for the library, the Carey Memorial Wing substantially increased the space for the basic science departments. Remodeling and expansion enabled all of the departments housed in the Cramer Memorial Building to increase their space by from thirty to fifty per cent. Construction was hardly finished when every square foot of space was occupied by the rapidly expanding research programs, bringing with them considerable increase in the numbers of the basic science faculty and technical staffs.

The Reverend Anthony F. Berens retired as Regent of the Medical School in 1955. He had been with the Medical School for thirty years and was responsible to a considerable extent for its development. He was a man who seemed to be devoid of external sentimentality, but he was so kind and understanding that he was the confidant of faculty and students alike for all those years. Father Berens passed away in 1959. His portrait hangs in the student reading room of the Medical Library, which is appropriately named the Reverend Anthony F. Berens, S. J. Reading Room.

Mr. James L. Quinlan became Business Manager of the Medical School upon the retirement of Mr. P. M. Sinsel in 1952. Appointment of full-time teachers and investigators in the clinical departments continued. Dr. Edward T. Sheehan, was appointed Assistant Professor of Psychiatry and Acting Chairman in 1954. A Department of Occupational and Environmental Medicine was formed and Dr. Elston L. Belknap became full-time Professor and Chairman in 1954. Dr. Walter Zeit was promoted to Associate Dean and Dr. Edward A. Bachhuber became an Associate Dean in 1958. Dr. Francis D. Murphy retired as Professor of Medicine and Chairman of the Department in 1958. Graduates of Marquette University School of Medicine over a period of thirty years will always recall the bedside teaching of Doctor Murphy at the Milwaukee County Hospital as their finest learning experience in Internal Medicine. Doctor Murphy was succeeded by Dr. Wil-

liam W. Engstrom, as full-time "Francis D. Murphy Professor of Medicine." This professorship is supported by a permanent endowment of $320,000.

It was inevitable that improvement of facilities followed development of the Faculty. In 1955 a grant of $50,000 gave the Department of Anatomy a completely equipped modern electron microscope laboratory. It is named the "Bob Quinn Memorial Electron Microscope Laboratory," a gift of the Milwaukee Braves Baseball Club. The Milwaukee Braves have given this laboratory continued yearly support. The fifth floor pent house on the Cramer Memorial Building was entirely rebuilt in 1959, at a cost of $250,000. This floor is now a completely air-conditioned modern animal facility. The Allen-Bradley Foundation of Milwaukee, through a grant of $200,000, established the "Allen-Bradley Medical Science Laboratory." It is located in the rebuilt laboratory building of the old Milwaukee County Hospital. It serves as an animal experimental laboratory for the members of all clinical departments, particularly investigators from the Milwaukee County General Hospital, the Wood Veterans Administration Hospital and the Milwaukee Children's Hospital. In 1962 a Clinical Research Center was established at the Milwaukee County General Hospital through a grant of $200,000 from the U.S. Public Health Service. In the summer of 1962 the Departments of Pathology and Pharmacology in the Cramer Memorial Building were completely remodeled at a cost of $300,000.

In the past few years many full-time appointments have been made in the clinical departments. In 1958 Dr. Edwin H. Ellison was appointed Professor and Chairman of the Division of Surgery. Dr. Eugene Turrell became Professor of Psychiatry and Chairman, and Dr. David W. Kersting, Professor and Chairman of the Department of Dermatology in 1958. Dr. Jay Jacoby was appointed Professor and Chairman of the Department of Anesthesiology in 1959. In 1960 Dr. Michael Laskowski, Professor of Biochemistry, was made life-time "Grace R. Schwarten, American Cancer Society, Professor of Biochemistry." Doctor Laskowski came to the Medical School shortly after World War II and is well-known for his work on enzymes. Three additional appointments were made in 1961. Dr. Richard F. Mattingly succeeded Dr. Roland S. Cron as Professor and Chairman of the Department of Gynecology and Obstetrics; Dr. Warren H. Kempinsky was made Chairman of the Department of Neurology and Dr. John R. Amberg, Chairman of the Division of Radiology.

On January 1, 1962, Dr. Harry Beckman, Professor of Pharmacology and Chairman of the Department, retired and was succeeded by Dr. Harold F. Hardman. Doctor Beckman was Professor of Pharmacology for practically forty years. His famous book, "Treatment in General Practice," was the most widely sold medical book in this country in its day. He always made a great effort to improve the teaching of Pharmacology and his courses were outstanding.

Fig. 4—The Eben J. Carey and Helene Carey Memorial Library Wing of Marquette University School of Medicine facing on North Sixteenth Street. This wing is continuous with the Marquette University School of Dentistry.

In the last twenty years a profound change has occurred in the configuration of the Faculty of the Medical School. Before World War II, the only paid members were in the basic science departments. At this writing, Marquette University School of Medicine has 41 full-time paid members of the clinical faculty and 37 part-time paid teachers in the clinical departments. In the basic science departments there are 38 full-time paid faculty members and 7 part-time members. The total number of paid employees of the Medical School is 409.

Those who devote their lives to medical education, particularly in administrative positions, pay a certain price. They never have peace-of-mind. The financial problems that beset private medical schools seem to be utterly insoluble. The sources of financial support for medical schools never keep pace with the spiraling developments in medical education. The deans and departmental chairmen are constantly struggling to introduce necessary improvements in teaching and research without adequate financial means to do it. Recent additions to the endowment of the Medical School are the John G. Thompson Fund of $42,000 in 1951; the J. C. Staff Endowment of $45,000 in 1956; the Ford Foundation gift of $1,603,711 in 1956; and the Oscar Plotkin Memorial Research grant of $81,540 in 1959. Total research, training, and teaching grants from all sources in the last fiscal year totaled $1,200,000. Total budget for the operation of all activities of the Medical School is $3,250,000 for the present fiscal year. The financial deficit for this year is over $200,000.

We have seen how the Medical School has developed from very meager beginnings. In all these years almost 3,500 physicians have been graduated. Some have become departmental chairmen in other medical schools and leaders in medical education. Others have earned enviable reputations in their chosen fields of specialization. Most had their undergraduate experience when the Medical School had

very limited facilities to offer. This proves again that people, teachers and students, are the most important element in any educational institution. The great majority of our graduates have become responsible citizens in their communities and deliver good medical service to the public. It is a source of justifiable pride to all the teachers of the past fifty years that their students have done so well.

In this short review of the history of Marquette University School of Medicine it has not been possible to mention the names and contributions of the large number of teachers, particularly volunteer clinical teachers and chairmen of the departments of the subspecialties of Medicine and Surgery who sustained the Medical School for so many years. They deserve eternal gratitude for the heritage they left the Medical School. This account has been limited to recounting the names of the chairmen of the major departments.

We have seen how Marquette University School of Medicine has evolved in the past fifty years. Its story undoubtedly closely resembles the development of many other medical schools in the country that grew out of the old proprietary schools. Our history is a true reflection of the development of medical education in the United States.

GERACI

MARQUETTE SPECIAL

Bacterial Endocarditis and Endarteritis Following Cardiac Operations

By JOSEPH E. GERACI, M. D., ALLAN J. D. DALE, M. D. and DWIGHT C. McGOON, M. D., Rochester, Minnesota

■ WITH THE advent of effective technics for the surgical correction of cardiac defects, the development of postoperative bacterial endocarditis became recognized as a distinct hazard and this syndrome has become an important clinical entity. The purpose of this study is to review the cases in which endocarditis has developed after cardiac operations at the Mayo Clinic.

The reported incidence of this complication is approximately 1 per cent.[1-3] The mortality rate appears to be high. Denton and associates[3] reported 12 deaths in 27 cases (44 per cent), while Fleming and Seal[4] reported 5 deaths in 9 cases (56 per cent). Postoperative bacteremia due to Pseudomonas aeruginosa encountered in 5 cases by Keown and co-workers[5] was fatal in every instance. Linde and Heins[1] reported 2 deaths in 7 cases (29 per cent), and Koiwai and Nahas[2] reported 3 deaths in 11 cases (27 per cent) (this excludes 1 case that appeared to follow a dental extraction 25 days after cardiac operation).

These patients present a serious diagnostic and therapeutic challenge because (1) the clinical picture of postoperative cardiac infections differs from the usual clinical syndrome of bacterial endocarditis, (2) usually antibiotic-resistant and occasionally uncommon microorganisms are encountered, and (3) localized sites of infection, difficult or impossible to eradicate with antibiotics, fre-

Presented at the 122nd Annual Meeting of the State Medical Society, Milwaukee, May 8, 1963, honoring the Fiftieth Anniversary of Marquette University School of Medicine, Milwaukee.

Doctor Geraci, a 1942 graduate of Marquette, is in the Section of Medicine, Mayo Clinic and Mayo Foundation; Doctor Dale is a fellow in Neurology; and Doctor McGoon, is in the Section of Surgery.

quently are present on or in the various foreign materials placed in the heart at operation. Many authors[1,3,4,6,7] have emphasized that splenomegaly, Osler's nodes, petechiae, and emboli are uncommon findings. They have pointed out that the early postoperative onset of unexplained, persistent fever is often the only sign and that this, if associated with positive blood cultures, should suggest the possibility of cardiac infection. Antibiotic-resistant microorganisms such as coagulase-positive Staphylococcus aureus and Ps. aeruginosa have been encountered frequently.[2-6,8] Less commonly encountered organisms have included the Achromobacter series.[1] Candida albicans,[9-11] coagulase-negative staphylococcus[12] and Histoplasma capsulatum.[13] The presence of silk sutures in skin may increase its susceptibility to infection with Staph. aureus from 500 to 10,000 times.[14] Also, in dogs the placement of an Ivalon patch in the heart followed by the administration of bacteria into the bloodstream may result in bacterial endocarditis, whereas dogs with only ventriculotomy do not develop endocarditis.[15] Usually, antibiotic therapy has not eradicated localized infections limited to foreign-body material in postcardiac surgical patients, so that reoperation with removal of the infected material has been necessary for recovery.[8]

Material. This report is based on patients who underwent cardiac, aortic, and vena caval operations at the Mayo Clinic from January 1, 1946, through December 31, 1962, and in whom a diagnosis of bacterial or fungal endocarditis was made postoperatively. The series totaled 24 patients (Table 1). Several other patients developed postoperative endocarditis after dismissal from our care, but these are not included. Cases 4 and 7 have been reported previously.[13,16]

Since approximately 4,300 cardiac or large-vessel operations (exclusive of coarctations of the aorta and lesions distal to this site) have been performed in the 17-year period, the incidence of postoperative endocarditis represented by the 24 patients is approximately 0.5 per cent. This is a low value, however, since the true total number of postoperative infections cannot be known. Necropsy was performed in all fatal cases except Cases 14 and 22.

Observations. The ages ranged from 6 to 72 years, 7 patients (29 per cent) being 16 years of age or younger. There were 13 females and 11 males.

Seventeen patients died (71 per cent). Of the 7 survivors, 2 (Cases 4 and 13) required a second operation for removal of a silk suture infected with Ps. aeruginosa before recovery was possible, while the other 5 were cured by antibiotic therapy alone.

Only one pathogenic microorganism was involved in each case; in 18 (75 per cent), it was either Staph. aureus (coagulase-positive) (12 cases) or Ps. aeruginosa (6 cases). The other pathogens were H. capsulatum (Case 7), an unidentified gram-negative bacillus (Case 8), Staph. epidermidis (coagulase-negative) (Cases 11, 22, and 23), and a beta-hemolytic streptococcus (Case 20). Twelve of the 18 cases seen from 1959 to the end of 1962 were infected with Staph. aureus.

Positive blood cultures were obtained during life in 20 cases. In 3 cases (Cases 1, 7, and 16) a pathogen was isolated only at necropsy from the heart; antemortem cultures were not obtained in Case 1 and they were repeatedly sterile in Cases 7 and 16. Positive cultures were obtained only at the time of reoperation in Case 13.

Postmortem cultures of tissue or blood or both obtained in 15 of the 17 fatal cases disclosed the same pathogenic microorganisms as those found during life in 13 of the 15 cases. In Case 11 the etiologic microorganism recovered antemortem was Staph. epidermidis; Staph. aureus obtained on postmortem culture presumably represented a contaminant. In the 4 instances in which both antemortem and postmortem Staph. aureus organisms were phage typed, the type was the same (Cases 6, 9, 10, and 12).

The strain of Staph. aureus in 8 of the 11 patients with positive blood cultures during life and the Staph. epidermidis in 1 patient were resistant to penicillin G, the organisms requiring 5 mcg. or more per milliliter to inhibit growth.

Four of the operations resulting in endocarditis were closed-heart procedures (mitral commissurotomies for mitral stenosis), and 20 were open-heart procedures. The pathogen following the open-heart procedures was either coagulase-positive Staph. aureus or Pseudomonas. Four patients (Cases 2, 3, 4, and 5) infected with Ps. aeruginosa were operated on during the period (1956) when the heart-lung apparatus was sterilized with benzalkonium chloride (Zephiran chloride),

TABLE 1—*Pertinent Data on 24 Patients With Postoperative Endocarditis*

Case	Sex, age	Cardiac lesion	Operation		Prophylactic antibiotics	Intracardiac foreign bodies	Pathogen	Onset of fever after operation	Emboli	Splenomegaly	Comment
			Date	Type							
1	F 27	Tetral. of Fallot	8/20/59	Open heart	Pen. G 600,000 u. day before, day of operation. Then 1,000,000 u. Pen. G combined with 0.5 Gm. DHS/day for 9 days	Silk sutures. Teflon prosthesis	Staph. aureus (postmortem culture only)	First 24 hr.	No	No	*Died* 9 days postop. No other specific antibiotic treatment given. Patient acutely ill postop. Fulminating infection. Clinical picture complicated by urticaria and angioneurotic edema. Necropsy.
2	M 14	Congen. aortic stenosis	11/20/56	Open heart	Same as Case 1 except combination for 10 days postop.	Silk sutures. Ivalon sponge around aorta	Ps. aeruginosa	10 days	No	No	*Died* 9 wk. postop. Infection suppressed with polymyxin B 50 mg. IM q. 6 hr. with cultures negative for 14 days; less bactericidal effect with polymyxin + tetracycline + Strep., polymyxin + neomycin or polymyxin + chloramphenicol. Total polymyxin treatment: 25 days. Necropsy.
3	M 31	Tetral. of Fallot	1/3/57	Open heart	Same as Case 1 except combination for 12 days postop.	Silk sutures. Ivalon sponge in VSD and in outflow tract	Ps. aeruginosa	12 days	No	No	*Died* after 6 days of polymyxin therapy 50 mg. q. 6 hr. and 3 wk. postop. of uncontrolled infection and congestive heart failure. Cultures remained positive during therapy. Necropsy.
4	F 13	ASD, patent ductus	10/25/56	Open heart	None preop.; same combination as in Case 1 for 10 days postop.	Silk sutures	Ps. aeruginosa	5 mo.	No	No	*Cure* with reoperation; case reported elsewhere.[16]
5	F 6	VSD	1/22/57	Open heart	Same as in Case 1 except combination for 9 days postop.	Silk sutures. Ivalon sponge in VSD	Ps. aeruginosa	6 days	No	No	*Died* 34 days postop. of uncontrolled infection, but only 1 of 11 antemortem blood cultures positive after 12 days' incubation. Polymyxin + Strep. + tetracycline and polymyxin + chloramphenicol given. Necropsy.
6	F 7	Tetral. of Fallot	5/26/59	Open heart	Tetracycline 250 mg. IM day before, day of, and 3 days after operation, then b.i.d. for 2 wk.	Silk sutures. Ivalon sponge in outflow tract	Staph. aureus (Pen. resistant)	3 mo.	No	Yes	*Died* 14+ mo. after onset of symptoms of infection and 17½ mo. postop. Treated with vancomycin 3 wk. 1st period, then vancomycin + penicillin G in large doses for 5 wk. Died abruptly 3 days after 3rd readmission and after 3 days of methicillin. Necropsy.
7	M 53	Mitral stenosis	9/22/59	Commissurotomy	Same as Case 1 except combination for 8 days	Silk sutures in left atrium	H. capsulatum at postmortem only	3 mo.	No	Yes	*Died* 13 mo. postop. of uncontrolled Histoplasma infection and congestive-heart failure. Therapy with amphotericin B intermittently for 4 mo. Necropsy. Previously reported.[13]
8	M 47	Mitral stenosis	9/8/52	Commissurotomy	Same as Case 1 except 1,200,000 u. Pen. alone per day for 3 days postop.	Silk sutures in left atrium	Unidentified gram-neg. bacilli	7 wk.	Yes, lung	No	*Cure.* Only bactericidal regimen was 0.25 Gm. neomycin and 25 mg. polymyxin q. 6 hr. for 2 wk. Patient alive and well after 10 yr.
9	Reported in detail in text of paper.										
10	M 57	Congen. aortic stenosis	6/14/61	Open heart	Same as Case 1 except combination for 4 days postop.	Silk sutures in aorta	Staph. aureus (Pen. sensitive)	2 wk.	No	Yes	*Died* 45 days postop. of congestive heart failure after 1 mo. of 4,000,000 u. cryst. Pen. G IM + 1 Gm. Strep. IM/day. Infection suppressed but not eradicated. Necropsy.
11	M 35	Mitral stenosis	4/1/59	Commissurotomy	Tetracycline 250 mg. IM preop.; 500 mcg. (oral) for 10 days postop.	Silk sutures in left atrium	Staph. epidermidis (Pen. resistant)	5 days	Yes, lung	Yes	*Probable cure. Died* 3 wk. after completion of 3 wk. of vancomycin therapy and 6 wk. postop. of protracted congestive heart failure. Blood cultures during and after treatment and at necropsy negative.

TABLE 1 *(continued)*

Case	Sex, age	Cardiac lesion	Operation		Prophylactic antibiotics	Intracardiac foreign bodies	Pathogen	Onset of fever after operation	Emboli	Splenomegaly	Comment
			Date	Type							
12	F 45	Mitral regurg.	2/11/60	Open heart	Tetracycline same as io Case 11 preop., then 500 mg./day IM for 5 days postop.	Silk sutures. Teflon in mitral ring	Staph. aureus (Pen. resistant)	First 24 hr.	Yes, lungs	Yes	*Died* abruptly 3+ wk. postop. and after 2 wk. of vancomycin therapy of pul. emboli and acute bact. endocarditis of mitral-valve ring and atrium.
13	Reported in detail in text of paper.										
14	F 9	Congen. aortic stenosis	11/9/61	Open heart	Erythromycin 100 mg. IM day before and morning of operation, then b.i.d. for 8 days postop.	Silk sutures at aortotomy site	Staph. aureus (Pen. sensitive)	14 days	No	No	*Died.* Reoperation 16 days postop.; died next day of hemorrhage. Had 2–3 days of vancomycin therapy. Infection limited to aortotomy site, with small abscess drained at base of site. No necropsy.
15	Reported in detail in text of paper.										
16	F 45	Mitral and tricuspid stenosis	5/24/54	Commissurotomy	Same as Case 1 except combination for 4 days postop.	Silk sutures in left atrium	Staph. aureus (only at postmortem; 3 antemortem blood cultures negative)	5 days	Yes	Yes	*Died.* Death 2 wk. postop. 9 days after onset of fever and chills. Inadequate therapy with erythromycin. Clinical picture obscured by pruritis, diffuse erythema of skin, jaundice, hypotension. Patient was thought to have drug reaction. Necropsy.
17	Reported in detail in text of paper.										
18	Reported in detail in text of paper.										
19	Reported in detail in text of paper.										
20	F 56	ASD	9/21/62	ASD closed with silk	None	Silk sutures	β-hemolytic streptococci (Pen. sensitive)	5 days	No (Petechia on neck and conjunctiva)	No	*Cure:* 3 mo. follow-up. Cryst. Pen. G 6,000,000 u./day for 3 wk. Good response.
21	Reported in detail in text of paper.										
22	M 53	Rheum. heart dis. with mitral stenosis and insuff.	12/23/60	Commissurotomy and plastic repair for mitral insuff.	Pen. G. 600,000 u. before and 400,000 u. plus Strep. 1 Gm. after operation. Then 1,000,000 u. Pen. G. and 1 Gm. Strep./day for 8 days postop.	Ivalon. Silk sutures	Staphylococcus (Pen. sensitive)	8 mo.	No	Yes	*Death* 14 mo. postop. of uncontrolled infection and renal insuff. No postmortem. Pen. G. + Strep. for 1 mo. controlled symptoms and blood cultures, but cultures positive again after therapy stopped. No reoperation: blood urea 252, 272 mg.
23	M 58	Aortic insuff. from previous bact. endocarditis	9/21/62	Aortic valve replaced by total 3-cusp Teflon valve	Pen. G. 600,000 u. before and 400,000 u. plus 1 Gm. Strep. Then 250 mg. tetracycline q. 8 hr. orally for 10 days	Teflon. Silk sutures	Staphylococcus (Pen. sensitive)	3 wk.	No	No	*Death* 5 wk. postop. of congestive heart failure. Bact. endocarditis at base of aortic prosthetic valve with abscess formation at postmortem.
24	F 36	Congestive heart disease with ASD	5/4/62	ASD closed with silk	None	Silk sutures	Staph. aureus (Pen. resistant)	5 days	No	No	*Cure:* 3 wk. of vancomycin (1 Gm. by vein b.i.d. q. 12 hr.) Temperature dropped promptly with therapy and convalescence was uneventful. Follow-up of 8+ mo.

Abbreviations: ASD = atrial septal defect; DHS = dihydrostreptomycin; IM = intramuscular (ly); Pen. G. = procaine penicillin G; Strep. = streptomycin; VSD = ventricular septal defect.

that is, by a "cold sterilization" technic. A fifth patient, infected with Ps. aeruginosa following surgical repair of a ventricular septal defect and encountered in this period, is not included in this series because of lack of follow-up information. The sterilization procedure has since been changed to the use of autoclaving and ethylene oxide for all non-autoclavable parts. Subsequent to this change we have seen two additional patients with postoperative Pseudomonas endocarditis (Cases 13 and 17).

The cardiovascular lesions were as follows:

1. Congenital heart lesions consisted of aortic stenosis in four cases, atrial septal defect in four (associated with patent ductus arteriosus in one and pulmonary stenosis in one), tetralogy of Fallot in three, ventricular septal defect in one, and ventricular septal defect, pulmonary stenosis, and aortic regurgitation in one.
2. Rheumatic heart lesions consisted of mitral stenosis in four cases, mitral and tricuspid stenosis in one, mitral regurgitation in one, mitral, aortic and tricuspid regurgitation in one, aortic stenosis in one, and aortic insufficiency from bacterial endocarditis in one.
3. Large-vessel lesions consisted of abdominal aortic aneurysm in one case and chemodectoma involving the superior vena cava in one.

Silk sutures were used in every case, and Teflon or Ivalon prostheses were inserted in 13 (Cases 1, 2, 3, 5, 6, 12, 13, 15, 17, 18, 21, 22, and 23). Infection of the silk sutures was proven in 4 (Cases 4, 10, 13, and 14) while infection of the prostheses was proven in 7 (Cases 2, 3, 5, 6, 15, 17, and 23); the pathogen involved was Ps. aeruginosa in 6 cases and Staph. aureus in 5.

The onset of fever and other symptoms of endocarditis occurred in the first week after operation in 11 cases, in the second to fourth week in 5, and in the fifth week or later in 8. Thus the endocarditis occurred within 1 month after operation in two thirds of the cases. However, in only 4 cases did the temperature rise in the first 24-hour period and remain up; in all others it returned to normal or almost normal before it rose again and new symptoms appeared. A positive blood culture was obtained early in the initial or subsequent febrile episodes in 19 cases. Of the remaining 5 patients, 1 died without blood cultures being obtained (Case 1), 3 had negative blood cultures at all times (Cases 7, 13 [except at reoperation], and 16), and 1 became afebrile with antibiotic therapy before positive blood cultures were obtained (Case 3).

Splenomegaly was observed in 9 patients and antemortem embolic phenomena in 5.

The results of necropsy performed in 15 of the 17 fatal cases—14 at this institution and 1 elsewhere—are summarized in Table 2.

Six patients underwent a second operation in an effort to remove infected tissue in and around the heart (Table 3). Two survived and have apparently been cured, while 4 died, 2 during the second operation.

Report of Illustrative Cases

Case 9. A 9-year-old girl underwent correction of congenital subvalvular aortic stenosis on January 20, 1959. Nine days previously she had developed low-grade fever and the tonsils and both tympanic membranes had been injected. A throat culture demonstrated only "usual flora." For 6 days before operation, tetracycline, 125 mg., was given every 6 hours by mouth. She became afebrile within 24 hours after the start of therapy and remained so.

At operation the subvalvular stenotic area was excised and the aortotomy wound closed with silk sutures. Immediately after operation the patient began to have chills and fever with the temperature fluctuating between 101 F. and 104 F. Blood cultures revealed Staph. aureus, and administration of vancomycin, 0.5 Gm. intravenously every 8 hours, was started. Two days later, on January 27, blood cultures were negative and tests showed an adequate bactericidal effect in the patient's serum in a dilution of 1:8. Vancomycin therapy was discontinued after 14 days. Her temperature was normal at this time. However, vancomycin therapy was started again 3 days later because chills and fever recurred and the same strain of Staph. aureus was again cultured from the blood. On February 25, reoperation disclosed a mycotic aneurysm at the aortotomy site. The aorta could not be reconstructed and the patient died during the operation.

Necropsy showed the mycotic aneurysm, healing vegetations on the aortic valve, and multiple infarcts in the brain, spleen, and kidneys. The same phage type of Staph. aureus was cultured from the spleen and from vena caval blood. There is no record of cultures of the heart blood and valve.

COMMENT. This patient was treated early in our evaluation of vancomycin treatment of staphylococcal endocarditis.[17] In retrospect, she received inadequate treatment with vancomycin, an adequately bactericidal antistaphylococcal agent. Necropsy showed that the valvular vegetations were healing well, and only a few organisms were seen on his-

TABLE 2—*Postmortem Findings*

Case	Postmortem cultures	Pathologic changes in heart and great vessels
1	*Staph. aureus* from tricuspid valve	Acute bacterial endocarditis of tricuspid and pulmonic valves with perforation of right pulmonary cusp and infundibular region of right ventricle. Gram-positive cocci in vegetations. Body embalmed before examination.
2	*Ps. aeruginosa* from spinal fluid, Ivalon sponge, aortic and mitral-valve vegetations	Mycotic aneurysm of ascending aorta. Extensive infarction in and around aorta at suture line and Ivalon sponge
3	*Ps. aeruginosa* from heart blood and pericardium	Vegetations on tricuspid valve and prosthesis in ventricular septal defect. Aneurysm of right ventricular wall at cardiotomy site. Separation of sutures holding prostheses
5	*Ps. aeruginosa* from heart blood and heart vegetation	Separation of Ivalon prosthesis from ventricular septum. Vegetations on right ventricular wall of the prosthesis and tricuspid valve
6	*Staph. aureus* from right ventricular vegetations, spleen and liver. Heart blood negative	Vegetations on Teflon graft in right ventricular outflow tract
7	*H. capsulatum* cultured from the mitral valve	Vegetations on mitral valve. Organisms morphologically compatible to H. capsulatum in vegetations on histologic examination
9	*Staph. aureus* from blood in inferior vena cava and spleen	Vegetations on aortic valve with perforation of right and posterior cusps. Mycotic aneurysm at aortotomy site. Organisms present in aortic-valve vegetations
10	*Staph. aureus* from aortic valve, lower lobe of right lung, and heart blood	Separation of aortic sutures, with false aneurysm of aorta. Active infection of aneurysmal wall. Extension acute subendocardial, myocardial infarcts
11	*Negative* for Staph. epidermidis from mitral-valve vegetations. Heart blood negative	Vegetations and bacteria on mitral and aortic valves. One aortic cusp perforated. Thrombus of left atrium. Staph. aureus cultured from mitral valve, felt to be a contaminant
12	*Staph. aureus* from cardiac blood	Acute vegetative endocarditis of mitral-valve ring and left atrium
15	*Negative.* Heart blood, mitral and aortic valves, and mitral prosthesis cultured	Vegetations at base of prosthetic aortic valve, and on anterior mitral leaflet and base of mitral prosthesis
16	*Staph. aureus* from right kidney, cerebrospinal fluid, and cerebellum. Mitral valve negative	Microabscesses in myocardium. Vegetations on mitral and aortic valves. Thrombus in left atrium extending into left ventricle. Body embalmed before examination. Gram-positive cocci noted in valve vegetations
17	Blood and mitral valve *negative* for Staph. aureus. Blood positive for E. coli	Healed mitral endocarditis. Small aneurysm of mitral valve. Prosthesis showed subacute inflammation
18	*Ps. aeruginosa* from aortic valve	Vegetations on aortic-valve leaflets and abscess of aortic-valve ring
23	*Coagulase-negative staphylococcus* from aortic-valve area	Vegetations at base of aortic prosthetic valve; perforation of cusp, separation of commissure, and formation of abscess behind right cusp pointing to pulmonary ring

tologic examination of valvular material. We now know that these serious staphylococcal infections following cardiac operations should be treated for at least a month with an adequately bactericidal agent. Today this patient would be given methicillin for 1 month instead of vancomycin.

Case 13. A 16-year-old girl underwent correction of a ventricular septal defect, infundibular pulmonary stenosis, and aortic insufficiency at the Mayo Clinic on January 7, 1960. Temporary extracorporeal circulation and induced cardiac asystole were used. The stenotic area was excised. The ventricular septal defect was closed with a Teflon patch, and a plastic revision with silk sutures was performed on the incompetent aortic valve. Silk sutures were also placed in the right ventricular incision and at the aortotomy site. The patient appeared to convalesce satisfactorily and was discharged 10 days later.

In August 1960, 7 months after operation, she became intermittently febrile and remained so despite prolonged adequate therapy with penicillin elsewhere. From November 1960 through February 1961, many blood cultures taken before, during, and after this therapy were negative.

She was readmitted in March 1961. She looked well physically. No splenomegaly was noted. The blood-hemoglobin value and the leukocyte count were normal. The sedimentation rate varied between 41 and 46 mm. in 1 hour (Westergren method). Again, eight blood cultures were negative. During 17 days in the hospital she had two 36 to 48-hour episodes of fever 5 days apart. She felt perfectly well before, between, and after these episodes. She was dismissed with an indeterminate diagnosis. Bacterial endocarditis was thought to be only a remote consideration.

Because of continuing periodic 36 to 48-hour febrile episodes occurring about every 2 weeks, she returned to our care in September 1961. Again she looked well and had no anemia. The spleen was not felt. The leukocyte count and sedimentation rate were unchanged. No blood cultures were obtained before operation. On reoperation on September 18 the only evidence of infection was a dangling silk suture covered with warty yellow vegetations at the aortotomy site, the suture lying almost free in the aortic lumen. Culture of this material and of blood from the left ventricle yielded Ps. aeruginosa, but cultures of pulmonary-artery blood were negative.

Convalescence was satisfactory and no febrile episodes have occurred for 15 months. No preoperative or postoperative antibiotic therapy was given for the Pseudomonas infection. However, 6 Gm. of methicillin a day was given for 10 days postoperatively because of low-grade fever for 8 days after operation.

COMMENT. This unusual patient, whose mild symptoms of infection were not mani-

fested until 7 months after operation and whose clinical course resembled that of periodic fever of Reimann, is the second one whose postoperative intracardiac Pseudomonas infection has been cured here by a second operation. The first patient was reported previously.[16] Our experience and that of others[18] make it doubtful that her infection would have been cured with seemingly adequate antibiotic therapy even if the diagnosis had been established after her first operation. Pseudomonas infections complicating cardiac operations and involving unabsorbable suture or prosthetic material are almost never cured with antibiotic therapy alone; reoperation is necessary if infection continues to be evident during therapy or if it recurs after a month of apparently adequate bactericidal therapy.

Case 15. A 24-year-old woman with rheumatic aortic and mitral insufficiency underwent repair of these valves on September 29, 1961. Temporary extracorporeal circulation, silk sutures, and Ivalon and Teflon prosthetic materials were used. No antibiotic prophylaxis was given before or after operation. The temperature rose to 104 F. on the second day. Blood cultures obtained on September 30 and October 1 were positive for penicillin G-resistant staphylococci. Treatment with oxacillin, 1 Gm. given intramuscularly every 2 hours, was started approximately 3 days after operation. Symptoms were controlled and the temperature fell to normal in 6 days. Under this regimen, serum assay revealed 198 mcg. of oxacillin per milliliter. Tests showed a bactericidal effect in a serum dilution of 1:32. Six blood cultures were negative during therapy. On October 11, a serum assay for oxacillin showed 73 mcg. per milliliter and the serum bactericidal test revealed a killing effect in a serum dilution of 1:16; the patient was then getting 1 Gm. of the drug intramuscularly every 4 hours, and its high levels in the serum were accounted for by moderate azotemia. Treatment was stopped on October 16, after 15 days of therapy, and the temperature then gradually rose to 101.6 F. by October 20; blood cultures on October 19 and 20 were positive again. Intramuscular injection of oxacillin was started again on October 20 and continued through November 5 (17 days), 1 Gm. being given every 4 hours. The temperature dropped to normal in 36 hours. On October 27, serum assay revealed 97 mcg. of the drug per milliliter and tests showed a bactericidal effect in a serum dilution of 1:16. Five blood cultures were negative—three during therapy and two after therapy was stopped on November 15. A wound culture on November 7 gave negative results. On November 14, apparently the patient began to bleed through her incision and it was thought that rupture was occurring at the site of aortotomy. On November 17, emergency operation became necessary. The patient was on the bypass machine for 248 minutes. Because of the highly friable aortotomy site, the surgeon was not able to reconstitute the aorta after the aortic and mitral-valve prostheses had been replaced. The entire operative site was infected. The aorta was perforated lateral to the suture line. At the conclusion of the operation the patient's heart action was not effective and she died on the table. Postmortem cultures of the aortic and mitral-valve areas and the prosthetic vegetations were negative. Cultures of the heart blood, and peritoneal fluid, and the splenic-infarct areas also were negative.

TABLE 3—*Observations at Reoperation*

Case	Operative findings
4	Dangling, vegetation-encrusted silk suture in left atrium Vegetation grew Ps. aeruginosa. Patient lived[16]
9	Aortic-valve vegetations. Mycotic aneurysm of aorta at aortotomy site. Died during reoperation, 36 days after initial operation. Postmortem cultures positive
13	Dangling, vegetation-encrusted silk suture at aortotomy site. Vegetation and left ventricular blood grew Ps. aeruginosa. Patient lived (see case report in text)
14	Purulent material, infected sutures and tissue at aortotomy site. Died day after reoperation, 16 days after initial operation. No necropsy
15	Vegetations on mitral and aortic-valve prostheses. Cultures negative (see case report in text). Died during reoperation 6 weeks after initial operation.
17	Vegetations on all Bahnson aortic-valve leaflets. Died 6 days after second operation and 20 days after initial one. Postmortem cultures positive (see case report in text).

COMMENT. Unfortunately, adequate parenteral oxacillin therapy was interrupted in this case after 15 days and the patient's symptoms recurred and blood cultures again became positive. They were again controlled with intramuscular oxacillin therapy. Serum levels and serum bactericidal effects of the drug were adequate with intramuscular injection of 1 Gm. every 4 hours; postoperative azotemia probably contributed to the higher serum levels of oxacillin. This case illustrates the severe damage that results from intravascular and intracardiac staphylococcal infection, resulting in death even when reoperation is attempted to control the hemorrhage and replace the infected prosthetic material. The negative post-treatment and postmortem cultures raise the question of an antibiotic cure in this patient even in the presence of prosthetic and silk suture material and even though the patient died of the mechanical defects of her postsurgical infection.

Case 17. A 40-year-old man with acquired aortic stenosis underwent debridement of the aortic valve and insertion of two prosthetic Bahnson aortic leaflets on July 6, 1962, with the aid of temporary extracorporeal circulation. No preoperative treatment was given. He was reoperated on the night of the same day because of hemorrhage of the internal mammary artery; the hemorrhage was controlled satisfactorily.

Postoperatively he had a variable temperature ranging up to 101.6 F. and 102.6 F. for 5 days and during this time he was given methicillin, 1 Gm.

every 6 hours intramuscularly. Then the temperature rose to 104 F. and a chill occurred. Thereafter the temperature rose to almost this level each day. Four blood cultures taken from July 11 through July 14 were positive for Ps. aeruginosa, the organisms growing out in from 2 to 7 days. The minimal inhibiting concentration and the minimal bactericidal concentration for polymyxin B was 3.12 mcg. per milliliter (tube dilution method). Also the organism was sensitive to colistin (disk method).

Polymyxin B, 50 mg. every 8 hours, was given from July 13 to 18. During this time a serum bactericidal test showed no effect of the drug, growth occurring in the undiluted serum (specimen taken 2 hours after intramuscular injection). The patient was then given colistimethate sodium, 75 mg. every 8 hours intramuscularly, from July 18 to 24.

The serum bactericidal test continued to show no killing even in undiluted serum. Reoperation on July 20 showed infection of the Bahnson leaflets; cultures of both were positive for Pseudomonas. The leaflets were removed and replaced with two other Bahnson leaflets. On July 24 the dose of colistimethate sodium was increased to 150 mg. every 6 hours (170-pound man) and continued until death on July 26, some 48 hours later. The patient's condition seemed to improve with this larger dose and he was afebrile for the first time on July 25. The spleen apparently was smaller and the left upper quadrant was less tender. He then abruptly became comatose, cyanotic, dyspneic, and hypotensive, developed Cheyne-Stokes respiration, convulsions, and hyporeflexia, and died 2 hours later.

The serum bactericidal test of a sample taken 2 hours after a 150-mg. dose of colistimethate sodium showed a bactericidal effect in a serum dilution of 1:2. Blood cultures were persistently positive throughout therapy; however, the culture taken on July 25, 1962, required 12 days of incubation before growth occurred.

Necropsy revealed infection of all the aortic leaflets and associated severe infection of the adjacent aortic ring with abscess formation. Pseudomonas was grown from the leaflets. Septic infarcts were noted in the kidneys and the spleen, and Pseudomonas was cultured from these areas. In many parts of the brain there was apparent mycotic vasculitis. The greatly hypertrophied heart had an area of relatively recent infarction (2 to 3 weeks' duration) in the lateral wall of the left ventricle. Many focal areas of very acute infarction of 12 to 24 hours' duration were noted. A generalized nonspecific interstitial myocarditis was also present.

COMMENT. This patient ran an acute septic postoperative course. In retrospect, we believe that he should have been given higher daily doses of polymyxin B or colistimethate sodium, as was given during the last day or two of life, and particularly during the second operation. Perhaps earlier operation and greater antibiotic coverage at the time of operation might have made a difference. The outcome in this patient was similar to that in the series of postoperative Pseudomonas infections seen in the 1956 and 1957 period (Cases 2, 3, and 5 in Table 1), which shows that Pseudomonas infections involving intracardiac foreign-body prostheses are not cured with antibiotic therapy alone.

Case 18. A 72-year-old white man was admitted on November 29, 1961, in shock from rupture of an arteriosclerotic aneurysm of the abdominal aorta. The aneurysm was excised on the day of admission and replaced with a woven-Teflon prosthesis. That evening the patient went into shock again; on reexploration, about 2,500 ml. of blood was evacuated from the peritoneal cavity, but no bleeding point was found. Convalescence was satisfactory and the patient was dismissed on December 24 in good condition.

A week later the patient was readmitted. He had fever and a Grade 2, apical systolic murmur. Reexploration the next day for left subphrenic abscess gave negative results. Two days later, the spleen was enlarged, the temperature increased, and the patient became toxic and confused. The increase in temperature persisted, and eight blood cultures were positive for Staph. aureus. Methicillin, 1 Gm. every 4 hours, was given intramuscularly for 22 days (total of 132 Gm.). The patient became afebrile in about 6 days and remained so.

Eight days after methicillin therapy had been discontinued, while the patient was still in the hospital, another episode of chills and fever occurred (temperature to 103 F.). Six blood cultures were again positive for Staph. aureus. Methicillin was given intramuscularly again in the same dose for 1 week. The patient became afebrile in 48 hours and remained so.

Then from February 11 through March 4, 1962, sodium oxacillin, 1 Gm. orally every 4 hours, was given; on March 5 the dose was reduced to 0.5 Gm. every 4 hours and on March 7 it was further reduced to 0.25 Gm. every 4 hours, and this dose was continued. The patient had continued to be afebrile all the while; however, during treatment, azotemia developed (blood urea to 144 mg. per 100 ml.). During the same time congestive heart failure also developed; this responded adequately to digitalis therapy and other measures. At dismissal on March 13 the patient was instructed to continue taking 0.25 Gm. of oxacillin every 4 hours. Many blood cultures during therapy had been negative.

The next day the patient was readmitted with a temperature of 102 F. Four blood cultures were positive. Dyspnea, mental confusion, and splenomegaly were noted. Treatment with methicillin was restarted, 1 Gm. given intravenously every 2 hours, and continued for 3 days. He became afebrile in 24 hours. After 3 days, 1 Gm. of methicillin was given every 4 hours intramuscularly. After 24 days of parenteral therapy, methicillin was replaced with sodium oxacillin, 0.5 Gm. given orally every 4 hours. The patient improved markedly and became alert. The azotemia disappeared, the value for blood urea decreasing to 42 mg. All blood cultures during therapy were negative. He was dismissed on April 30 with instructions to continue taking 0.5 Gm. of oxacillin every 4 hours.

The patient was readmitted on July 9. He had done well in the interim, had remained afebrile, and had continued taking oxacillin. The apical murmur was unchanged. Antibiotic treatment (now totalling 115 days) was stopped. Then the patient was ob-

served for 1 week and dismissed on July 17 having been afebrile while he was in the hospital. Six blood cultures during the antibiotic-free period were negative.

The patient was readmitted on July 19 with chills and fever again and moderate hypotension. A single blood culture was positive for Staph. aureus. Methicillin, 1 Gm., was given intravenously every 4 hours for 3 days and then was replaced with 0.5 Gm. of oxacillin given orally every 4 hours. The temperature rose to 102 F. only on the first day in the hospital and then remained normal. Five subsequent blood cultures were negative for staphylococci. The patient was dismissed on July 25.

He was readmitted on July 29 for the sixth time with chills and fever and mild hypotension. Blood cultures were negative for Staph. aureus, but 10 were positive for Escherichia coli. Methicillin, 1 Gm., was given intravenously every 2 hours for 3½ days and then 1 Gm. was given intramuscularly every 4 hours for a total treatment period of 30 days as of the time of death. During this period the patient was given also various combinations of antibiotics for his E. coli septicemia, including tetracycline plus streptomycin, chloramphenicol plus streptomycin, tetracycline plus polymyxin B, and colistimethate sodium plus chloramphenicol. He did not respond to treatment, and chills and fever continued. He deteriorated, developed increasing azotemia and bacteremic shock, became unresponsive and comatose on August 25, and died abruptly on August 28, 1962.

Blood cultures remained negative for staphylococci before and during therapy but remained positive for E. coli despite antibiotic therapy. Tests revealed a bactericidal effect of methicillin in dilutions of serum varying from 1:2 through 1:8 during therapy. No serum bactericidal tests were made during treatment for E. coli septicemia.

Necropsy revealed healed mitral endocarditis with a small aneurysm of the mitral valve. Cultures of the heart blood, spleen, and mitral valve were negative for staphylococci. Cultures of the aortic prosthesis were not obtained because of contamination at the time of necropsy.

COMMENT. This patient had six hospital admissions and four courses of methicillin-oxacillin therapy intermittently during 8 months. After congestive heart failure and general debility developed, re-exploration to see whether the Teflon graft was infected with staphylococci was thought too risky and it was decided to give sodium oxacillin continuously by mouth. This case illustrates one of the risks of prolonged antibiotic prophylactic therapy, namely superinfection with a gram-negative organism and resulting bacteremic shock and death.

In retrospect, it seems that the initial course of parenteral methicillin treatment may have been inadequate. Only the last course of parenteral therapy, given for a 30-day period, seems to have been adequate. Inasmuch as oxacillin by mouth gives variable absorption from the gastrointestinal tract and hence variable serum levels, and since serum bactericidal tests usually show a killing effect only in a 1:2 dilution of the patient's serum when 1 Gm. doses are given orally every 4 hours (adequate for simple bacteremias but apparently not always for bacterial endocarditis),[19] patients with serious, life-threatening postoperative intracardiac or intravascular staphylococcal infections should not be treated with oxacillin by mouth but by methicillin administered parenterally. The absence of staphylococci from the cultures made at necropsy suggests that the last course of prolonged parenteral therapy with methicillin probably cured the staphylococcal infection. Perhaps patients of this type would do best if they were given large daily doses of methicillin initially for a few days (intermittent intramuscular and intravenous therapy every 2, 3, or 4 hours [12 to 24 Gm. per day]), before they are given a regimen of 1 Gm. every 3 or 4 hours for a minimum of 1 month.

Case 19. A 26-year-old woman underwent closure of a congenital atrial septal defect and valvulotomy for pulmonary stenosis on September 14, 1962. Temporary extracorporeal circulation was used. The foramen ovale and the opening in the pulmonary artery were closed with silk sutures; no other foreign material was introduced. Signs and symptoms of infection appeared some 5 days later. Four blood cultures were positive for Staph. aureus, which was resistant to penicillin G (more than 10.0 mcg. per milliliter), but sensitive to methicillin (less than 5.0 mcg. per milliliter). Methicillin, 1 Gm. every 4 hours, was given intramuscularly from September 19 through October 17. Five serum bactericidal tests during therapy indicated adequate effect. The patient's temperature fell gradually over a 2-week period. Blood cultures remained positive for 3 days, however, after therapy was started and then became negative and remained so throughout and subsequent to treatment. The patient has remained well for 3 months after dismissal.

COMMENT. It is presumed that this patient had bacterial endocarditis, although she could well have had only bacteremia without involvement of the endocardium or the silk suture material. The case illustrates the principle that infections following repairs on the heart should be treated early with adequately bactericidal antibiotics for at least a month. Reoperation is performed only if symptoms and positive blood cultures persist or recur after such treatment.

Case 21. A 66-year-old man had signs and symptoms of superior vena caval obstruction. Roentgenograms showed a mass in the right upper part of the mediastinum. Preoperative angiograms revealed a high superior vena caval obstruction. Operation on

October 24, 1960, revealed a chemodectoma of the anterior mediastinum with superior vena caval obstruction. At operation a Teflon graft was inserted between the superior vena cava and the right atrium. Postoperatively, cobalt-60 therapy was given from November 8 through December 3. The patient had a low-grade fever for 10 days after operation; during this time some serosanguinous fluid flowed from the drainage tube and a month later a small air cyst at the middle of the wound was aspirated of 30 ml. of air and 0.5 ml. of pink serous material. From this material was grown Staph. aureus sensitive to 0.5 mcg. of penicillin G per milliliter. The patient was given 600,000 units of procaine penicillin G twice a day for 6 days. Postoperative convalescence was essentially uneventful except for the mild wound infection, which was healed completely at dismissal 6 weeks after operation.

The patient returned on March 21, 1961. Eight weeks prior to his return and approximately 3 months after the operation, he had developed weakness, sweats, recurrent chills, and fever. These continued despite antibiotic therapy at home. The wound was well healed. He had no heart murmurs and no splenomegaly or other evidence of infection elsewhere in the body. Three blood cultures obtained on consecutive days revealed Staph. aureus of the same phage type and sensitivity as noted previously. Methicillin, 1 Gm. every 4 hours, was given intramuscularly from March 23 through April 16, 1961. Symptoms disappeared, the temperature returning to normal in 4 days. The patient was dismissed as quite well after therapy. Tests revealed that his serum was adequately bactericidal throughout therapy. Blood cultures became negative after 3 days of therapy, and 12 blood cultures during and after treatment were negative. The patient has remained well for 23 months.

COMMENT. If this patient had not remained well and if the blood cultures had become positive after methicillin therapy, almost certainly he would have been reoperated on to see whether the graft was infected. Although the infection here could have been a simple bacteremia without vascular or cardiac involvement, the sequence of events and findings support a diagnosis of endophlebitis. Such patients should be treated as if they had endocarditis or endarteritis. The efficacy of methicillin in such cases is well demonstrated.[20]

Discussion. Postoperative endocarditis poses a serious problem. Although the incidence is fortunately low, the great financial expense involved in its therapy, the excessive morbidity, and the high mortality demand maximal efforts to prevent and treat it.

The microorganisms encountered are usually resistant to antibiotics and may be uncommon pathogens. We had no instances of the mixed cardiac infection that rarely occurs in nonpostoperative endocarditis.[21]

The only common initial clinical finding of endocarditis following cardiac operations has been fever, or fever and chills. This may coincide with the febrile reaction that usually follows cardiac operations, and may lead to confusion and delay in diagnosis unless blood cultures are obtained. The onset of the febrile course of the endocarditis often occurs during the immediate postoperative period but may be delayed for several weeks or even months, the patient appearing well in the interim. Other clinical signs such as embolic phenomena, petechiae, and splenomegaly, although significant, are much less consistently present and may not appear early in the course of the illness. Further diagnostic difficulties may be encountered in the occasional patient who has negative blood cultures; in such a case, if fever persists beyond the first few postoperative days, the patient should be presumed to have endocarditis, and blood cultures should be taken and therapy started even if the blood cultures prove to be negative.

Though difficult from the diagnostic standpoint, these infections have posed an even greater problem in management. When the diagnosis becomes established and the pathogen known, best results are obtained by the early use of a bactericidal antibiotic regimen, giving adequate daily doses for a sufficiently long period and regulating the course of treatment by means of serum bactericidal tests, occasionally by means of serum assays, and rarely by means of in vitro study of the organism.[22,23] However, not infrequently even with seemingly adequate antibiotic therapy, the disappearance of fever, and the appearance of negative blood cultures, it becomes apparent that the infection has only been suppressed and not eradicated. This is true in those patients with unabsorbable foreign-body suture material and prostheses within the heart.

Although 17 of our 24 patients died, not all deaths are attributed to the endocarditis. We believe that 10 of the 24 patients (42 per cent) were cured of their endocarditis. Two were cured by surgical treatment alone (Cases 4 and 7); in these, Pseudomonas infections had their onset 5 and 7 months after the initial operation. Two patients were cured with vancomycin (Cases 11 and 24); 1 of these had a mitral commissurotomy complicated by infection with a penicillin G-resistant coagulase-negative staphylococcus, and the other had repair of an atrioseptal de-

fect with silk suture material alone, and both had the onset of infection 5 days after operation. One patient (Case 8) was cured with polymyxin B and neomycin in combination. One (Case 20), cured with penicillin G alone, had had repair of an atrioseptal defect with silk sutures alone and an onset of symptoms 5 days after operation. Four patients apparently were cured with methicillin or oxacillin or the two combined (Cases 15, 18, 19, and 21). Of these, patient 15, who received intramuscular injections of sodium oxacillin alone, had Teflon and Ivalon prosthetic replacement and the use of silk sutures for rheumatic aortic and mitral valvular defects, and cultures during and after therapy and at necropsy were negative; patient 19, who was cured with 1 month of methicillin therapy alone, had repair of an atrioseptal defect with silk suture and a commissurotomy for pulmonary stenosis, and had her onset of symptoms 4 days after operation.

Most patients apparently cured with antibiotic therapy alone had had repair of an atrioseptal defect with silk suture material or commissurotomy for valvular stenosis, or both operations, and most of them apparently had the onset of infection soon after operation, usually within 5 days. The diagnosis of bacterial endocarditis in these patients without foreign-body prosthesis cannot be proved; they might have had simple bacteremias. However, they presented the same clinical course and appearance as did the other patients in this group so that we presumed they had bacterial endocarditis and treated them accordingly.

We still cannot say whether patients with bacterial endocarditis involving foreign-body prosthetic material can be cured with antibiotic therapy alone. Case 15 represents the closest that we have come to such a cure. It is possible, however, that the vegetative material on the aortic and mitral valvular areas and the prosthetic material were not sampled adequately in this case to determine whether the infection continued to be active. However, since three cultures of the valvular material and the heart blood, the peritoneal fluid, and the splenic infarcted areas were all negative, one can presume that an antibiotic cure might have resulted had not the unfortunate complication of aortic rupture and bleeding required reoperation, followed by death.

Factors contributing to the management difficulties and poor treatment results are the presence of infection with usually virulent antibiotic-resistant and occasionally uncommon microorganisms, the presence of unabsorbable foreign material (sutures, prostheses) in the heart and great vessels which act as a nidus of infection that is difficult or impossible to eradicate with antibiotics alone, delayed suspicion regarding the correct diagnosis in the immediate postoperative period, and late inadequate antibiotic therapy.

One should suspect complicating intracardiac infection if the patient's immediate postoperative condition deviates at all from the usually mild febrile reaction that occurs after cardiotomy with extracorporeal circulation. Normally, after operation in such a patient the temperature usually increases up to 101 F. or 102 F. and occasionally up to 104 F., with the peak usually occurring 48 to 72 hours after operation. The temperature then declines to normal by the fifth or sixth day. During this interval the patient does not look very sick or toxic and does not have chills. Therefore, any patient who develops high fever, chills, and a toxic appearance even during the first 72 hours, or who has a high temperature after the first few days, should be suspected of having intracardiac infection. Adequate blood cultures should be taken, at hourly intervals if necessary, and the patient then started on massive appropriate bactericidal antistaphylococcal therapy. At present this would mean the giving of methicillin intermittently, 1 Gm. intravenously and 1 Gm. intramuscularly every 2, 3, or 4 hours (12 to 24 Gm. per day) depending on the patient's condition, until the results of blood cultures are known. If the infection is due to a penicillin G-resistant strain of staphylococcus, the doses of methicillin may be reduced after the infection has been brought under control and may be continued at 1 Gm. intramuscularly every 3 or 4 hours along with probenecid if tolerated, depending on the results of the serum bactericidal tests, for at least 30 days. If the staphylococcus is sensitive to penicillin G, then adequate doses of the aqueous crystalline form of this preparation may be substituted for methicillin. If the infection proves not to be staphylococcal, the antibiotic regimen can be altered accordingly.

The importance of infected foreign-body material is emphasized by the fact that two of seven survivors in this group (Cases 4 and 13) required surgical removal of the infected material before recovery could occur. The

literature contains many examples of similar cases.[8,10,18,24] A patient who was seen at the Mayo Clinic but not included in this series and who had developed an aortic aneurysm and endarteritis following resection performed elsewhere for coarctation of the aorta has been reported previously.[25] The causative organism was a "gram-negative bacillus, tentatively classified as a member of the genus Alcaligenes." Cure was obtained by excision of the aneurysm, which contained infected suture material, and insertion of an aortic homograft; little preoperative and postoperative antibiotic therapy directed against this organism was given. Such reports together with the experience recorded in this study suggest that in many instances reoperation may well be the only means of curing some postoperative intracardiac infections. In retrospect, it is clear that in Cases 6 and 10 serious consideration should have been given to reoperation early in the postoperative period, in Case 6 at the time of the first relapse after the first period of vancomycin therapy, and in Case 10 during treatment when the blood cultures became positive again during apparently adequate bactericidal therapy. However, on occasion, because of the destructive nature of these infections, surgical repair of the infected area may be impossible, as in Cases 9 and 15.

We have adopted the policy of first giving patients with postoperative intracardiac infections an adequate trial of effective bactericidal antibiotic therapy for a period of 30 days before considering reoperation. If the patient remains well for at least 3 months, cure may be presumed. If relapse occurs or if symptoms and bacteremia are not controlled, then early reoperation should be seriously considered to see whether the foreign-body suture or prosthetic material has become infected and can be removed, provided the patient's general condition permits a further operation. If the cardiac status and debility do not permit reoperation, then long-term therapy with adequate daily doses of an appropriate bactericidal agent should be given either orally or parenterally.

Optimal therapeutic results and the highest cure rate will be obtained in these patients if the cardiac surgeon, the cardiologist, the microbiologist, and the specialist in infectious disease and antibiotic therapy work as a team in the antibiotic management of these patients.

Prevention is no less difficult than the diagnosis and management of postcardiotomy infection. Four patients in our series (Cases 2, 3, 4, and 5) were thought to have acquired their Pseudomonas infection from use of the heart-lung apparatus at a time when it was being sterilized with benzalkonium chloride, a "cold sterilization" technic now known to be ineffective against Pseudomonas. The use of ethylene oxide for the nonautoclavable parts and of autoclaving for all smaller parts of the heart-lung machine has tended to eliminate this factor, in our experience.

Pseudomonas endocarditis in general is difficult to treat and the results of previous antibiotic therapy have been poor. This entity is still rare and only about 7 patients are known to have been cured,[18,26] including the two reported herein. Three of the 7 cures were with antibiotics—2 with polymyxin B and 1 with neomycin.[18] Three were cured by reoperation (2 in this series and 1 by Sykes and colleagues[18]) and one apparently by splenectomy.[16]

Apparently thus far no intracardiac Pseudomonas infection following heart operations has been cured by antibiotic therapy alone. Of our 7 patients, only 2 of the 3 that were reoperated on survived. In these 2 the only site of infection was a small silk suture, which was removed readily. The third patient had all the leaflets of the prosthetic Bahnson aortic valve involved with the Pseudomonas infection and there was an associated severe infection of the adjacent aortic ring with the formation of an abscess. The other 4 patients showed variable responses to polymyxin B alone or to polymyxin B combined with other antibiotic agents; they were not reoperated on and they all succumbed to their infection.

Patients developing intracardiac Pseudomonas infection after operations on the heart with or without the use of any unabsorbable foreign-body material probably should be handled like those developing staphylococcal infection. We believe that they should be given maximal doses of polymyxin B. or colistimethate sodium alone if an adequate serum bactericidal effect is achieved, or one of these in combination with other antibiotics, possibly tetracycline and streptomycin. If symptoms are controlled, blood cultures become negative, and the serum gives a good bactericidal effect, we would continue therapy for a month. On the other hand, particu-

larly in the cases in which unabsorbable intracardiac foreign-body material is used, if symptoms are not controlled, if the blood cultures remain positive, and if an inadequate bactericidal effect is achieved with therapy, then early reoperation should be seriously considered to see whether a focus of infection can be removed while the patient is under adequate antibiotic cover. The doses of polymyxin B should be larger than usual (at least 75 mg. intramuscularly every 6 hours), and the doses of colistimethate sodium should be no less than 300 mg. per day and preferably 100 to 150 mg. every 6 hours given intramuscularly, that is, 6 to 10 mg. per kilogram of body weight.[27,28] Not enough patients with Pseudomonas endocarditis have been encountered and treated with either polymyxin B or colistimethate sodium alone or in combination with other antibiotics to enable one to say what an optimal antibiotic regimen would be. In one of our patients with Pseudomonas infection given polymyxin B alone, the addition of gamma globulin to the treatment regimen did not produce any greater bactericidal effect as determined by the serum bactericidal test.[29]

The value of prophylactic antibiotic therapy in the cardiac surgical patient has received little adequately controlled study. In our series all except patients 4, 15, and 24 received variable amounts of antibiotics before and after operation, which now must be considered inadequate therapy and ineffectual. Whether this prophylactic therapy had any preventive value or indeed helped to initiate some of the postoperative infections, one cannot say. In at least one case (Case 14) the administration of erythromycin before and after operation may have obscured the picture of infection for 2 weeks. The 7 patients reported by Keown and colleagues,[5] the 20 reported by Denton and associates,[3] and the 1 reported by Kelsch and Thomson[12] all received prophylactic antibiotic treatment. Lord and colleagues[6] thought the prophylactic use of antibiotics of questionable value. McKittrick and Wheelock,[30] in a study of 175 patients, failed to demonstrate "benefits which are necessary to compensate for the discomfort, the expense and the possible dangers associated with the prophylactic use of antibiotics following most elective operations on the gastrointestinal and biliary tract." The same may be true of cardiac surgical patients. Until this question can be settled by controlled studies, it would seem that if any antibiotic is to be used prophylactically it should be methicillin or the parenteral form of oxacillin, which are effective penicillinase-resistant bactericidal antistaphylococcal agents. One gram may be given intramuscularly every 3 or 4 hours the day before, the day of, and for several days after cardiac operation.

Summary and Conclusions. This report concerns 24 patients who developed intracardiac or vascular infection following cardiac or vascular operations at the Mayo Clinic. The crude incidence of this complication was about 0.5 per cent. Seventeen of the 24 patients (71 per cent) died during reoperation or in the immediate postoperative period. However, it was thought that 10 patients, or 42 per cent, were probably cured of their infection, although some of these died from other causes. Optimal treatment results will be obtained by early diagnosis and early adequate bactericidal antibiotic therapy. Close cooperation between cardiac surgeon, cardiologist, microbiologist, and the specialist in antibiotic therapy is desirable. Reoperation should be seriously considered if the patient does not respond to or relapses after adequate antibiotic therapy. The question of preoperative and postoperative prophylactic therapy for cardiac surgical patients has not been settled. Apparently no adequate control studies with the new semisynthetic antistaphylococcal penicillins have been reported.

It is concluded from this study and a review of the literature that the diagnosis and management of endocarditis following cardiac operations present a most serious problem because of the high morbidity and mortality caused by this complication and the continued serious economic drain on the patient and family.

Addendum. Since this report was prepared, a further review of our surgical patients in 1962 who had only a partial or total prosthetic valve replacement, including also those patients in whom the diagnosis of infection was made after they left the Mayo Clinic, indicates that the incidence of postoperative staphylococcal infection is closer to 10 per cent. Therefore, it seems imperative that those individuals who need a prosthetic valve replacement be given adequate antistaphylococcal antibiotic prophylaxis as noted above.

REFERENCES

1. Lindc, L. M., and Heins, H. L.: Bacterial endocarditis following surgery for congenital heart disease, New England J. Med. 263:65–69 (July 14) 1960.
2. Koiwai, E. K., and Nahas, H. C.: Subacute bacterial endocarditis following cardiac surgery, A.M.A. Arch. Surg. 73:272–278 (Aug) 1956.
3. Denton, Clarence, Pappas, E. G., Uricchio, J. F., Goldberg, Harry, and Likoff, William: Bacterial endocarditis following cardiac surgery, Circulation 15: 525–531 (Apr) 1957.
4. Fleming, H. A., and Seal, R. M. E.: Staphylococcal infection following cardiac surgery, Thorax. 10:327–337 (Dec) 1955.
5. Keown, K. K., Gilman, R. A., and Bailey, C. P.: Open heart surgery; Anesthesia and surgical experiences, J.A.M.A. 165:781–787 (Oct 19) 1957.
6. Lord, J. W., Imparato, A. M., Hackel, Alvin, and Doyle, Eugenie F.: Endocarditis complicating open-heart surgery, Circulation 23:489–497 (Apr) 1961.
7. Hoffman, F. G., Zimmerman, S. L., Bradley, E. A., and Lapidus, B.: Bacterial endocarditis after surgery for acquired heart disease; report of two cases and review of literature, New England J. Med. 260:152–158 (Jan 22) 1959.
8. Bahnson, H. T., Spencer, F. C., and Bennett, I. L., Jr.: Staphylococcal infections of heart and great vessels due to silk sutures, Ann. Surg. 146:399–406 (Sept) 1957.
9. Hyun, B. H., and Collier, F. C.: Mycotic endocarditis following intracardiac operations, New England J. Med. 263:1339–1341 (Dec 29) 1960.
10. Kay, J. H., Bernstein, Sol, Feinstein, Donald, and Biddle, Marjorie: Surgical cure of *Candida albicans* endocarditis with open-heart surgery, New England J. Med. 264:907–910 (May 4) 1961.
11. Sanger, P. W., Taylor, F. H., Robicsek, Francis, Germuth, Frederick, Senterfit, Lawrence, and McKinnon, George: Candida infection as a complication of heart surgery; review of literature and report of two cases. J.A.M.A. 181:88–91 (July 14) 1962.
12. Kelsch, Joan V., and Thomson, N. B., Jr.: Bacterial endocarditis complicating repair of a ventricular septal defect; report of case cured after removal of silk sutures, New England J. Med. 265:1245–1248 (Dec 21) 1961.
13. Palmer, R. L., Geraci, J. E., and Thomas, Betty J.: Histoplasma endocarditis; report on patient treated with amphotericin B, with review of amphotericin B therapy for histoplasmosis, Arch. Int. Med. 110: 359–365 (Sept) 1962.
14. Elek, S. D.: Experimental staphylococcal infections in skin of man, Ann. New York Acad. Sc. 65:85–90, 1956.
15. Barney, J. D., Williams, G. R., Cayler, G. G., and Bracken, E. C.: Influence of intracardiac prosthetic materials on susceptibility to bacterial endocarditis. (Abstr.) Circulation 26:684 (Oct) 1962.
16. Teitel, Maurice, and Florman, A. L.: Postoperative endocarditis due to Pseudomonas aeruginosa, J.A.M.A. 172:329–333 (Jan 23) 1960.
17. Geraci, J. E., and Heilman, F. R.: Vancomycin in treatment of staphylococcal endocarditis, Proc. Staff Meet., Mayo Clin. 135:316–326 (June 8) 1960.
18. Sykes, Charles, Beckmuth, J. R., Muller, W. H., and Wood, J. E., Jr.: Postoperative endoauriculitis due to Pseudomonas aeruginosa cured by second operation, Arch. Int. Med. 110:113–117 (July) 1962.
19. Geraci, J. E., Hoffmeister, R. T., Nichols, D. R., and Needham, G. M.: Preliminary clinical and laboratory experiences with new oral penicillin: 5-Methyl-3-phenyl-4-isoxazolyl penicillin, Proc. Staff Meet., Mayo Clin. 37:137–149 (Feb 28) 1962.
20. Allen, J. D., Roberts, C. E., Jr., and Kirby, W. M. M.: Staphylococcal septicemia treated with methicillin; report of twenty-two cases, New England J. Med. 266:111–116 (Jan 18) 1962.
21. Dale, A. J. D., and Geraci, J. E.: Mixed cardiac valvular infections; report of case and review of literature, Proc. Staff Meet., Mayo Clin. 36:288–294 (June 7) 1961.
22. Geraci, J. E.: Antibiotic therapy of bacterial endocarditis; therapeutic data on 172 patients seen from 1951 through 1957; additional observations on short-term therapy (two weeks) for penicillin-sensitive streptococcal endocarditis, M. Clin. North America, July, 1958, pp. 1101–1140.
23. Jawetz, Ernest: The "tough case" of bacterial endocarditis, Circulation 20:430–437 (Sept) 1959.
24. Schimke, R. T., Black, P. H., Mark, V. H., and Swartz, M. N.: Indolent *Staphylococcus albus* or *aureus* bacteremia after ventriculoatriostomy; role of foreign body in its initiation and perpetuation, New England J. Med. 264–270 (Feb 9) 1961.
25. Martin, W. J., Kirklin, J. W., and DuShane, J. W.: Aortic aneurysm and aneurysmal endarteritis after resection for coarctation; report of case treated by resection and grafting, J.A.M.A. 160:871–874 (Mar 10) 1956.
26. Lloyd, K. M., II, and Gordon, J. N.: Bacterial endocarditis due to *Pseudomonas aeruginosa*, Ann. Int. Med. 55:814–817 (Nov) 1961.
27. Fekety, F. R., Jr., Norman, P. S., and Cluff, L. E.: Treatment of gram-negative bacillary infections with colistin; toxicity and efficacy of large doses in forty-eight patients, Ann. Int. Med. 57:214–229 (Aug) 1962.
28. Petersdorf, R. G., and Plorde, J. J.: Colistin—a reappraisal, J.A.M.A. 183:123–125 (Jan 12) 1963.
29. Waisbren, B. A., and Lepley, D., Jr.: Antibiotics and gamma-globulin in Pseudomonas infections, Arch. Int. Med. 109:712–716 (June) 1962.
30. McKittrick, L. S., and Wheelock, F. C., Jr.: Surgeon at work; routine use of antibiotics in elective abdominal surgery, Surg. Gynec. & Obst. 99:376–377 (Sept.) 1954.

DETERGENTS IN WISCONSIN SURFACE WATERS

Monthly samples taken at 36 monitoring stations on Wisconsin lakes and streams have been checked for the detergent alkyl benzene sulfonate (ABS) content since January 1963. With very few exceptions the ABS content of these waters have been below the accepted level for drinking water, 0.5 mg./l. The Rock River at two locations showed concentrations of 0.5 and 0.56 mg./l., but only once during the six month period. Other values for the Rock River were well below 0.5 mg./l. Milwaukee River water showed a concentration above the drinking water standard at only one time, although several samples approached this concentration. The Root River at Racine has consistently shown detergent concentrations about 0.5 mg./l., with values ranging up to 3.1 mg./l. All other samples had low ABS concentrations, generally below 0.2 mg./l.

Recent studies made by the United States Public Health Service[1] indicate that concentrations of ABS up to 1000 mg./l. have virtually no odor, and that concentrations below 16 mg./l. in water produced no detectable taste.—Wisconsin State Laboratory of Hygiene *Newsletter*, June 1963.

REFERENCES

1. Cohen, Jesse M.: Taste and odor of ABS in water, J. Amer. Water Works Assn. 55:587 (May) 1963.

Laboratory Diagnosis of Collagen Diseases

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■ ALTHOUGH the term "collagen diseases" is widely used, it is with limited understanding and is, therefore, not a precise one. Nevertheless this term may be retained primarily because of its phonetic simplicity and common usage. Numerous authors have indicated that a more reasonable term would be "connective tissue diseases" because in the disorders under discussion, the tissue abnormalities are not restricted to collagen alone. The term collagen is derived from the Greek word kolla, meaning glue or binding substance, which we call connective tissue. Some of the diseases given this designation are referred to as "autoimmune diseases," and it seems quite plausible that in the future a few of these disorders may be placed with others under a new classification. Symmers[1] in commenting on collagen diseases enumerates 65 conditions listed by authors as a "collagen disease."

The disorders to be considered are: (1) rheumatoid arthritis, (2) systemic lupus erythematosus, (3) polyarteritis, (4) thrombotic thrombocytopenic purpura, (5) progressive systemic sclerosis, and (6) dermatomyositis. Various combinations of these disorders have been reported with overlapping histologic features suggesting that they may have a common underlying pathophysiology. It was with this in mind that Boyd[2] compared these disorders to an iceberg concept which utilizes a single huge iceberg below water level having several islands projecting above the surface which may be called rheumatoid arthritis, systemic lupus erythematosus, progressive systemic sclerosis, and perhaps hemolytic anemia. Clinical recognition comes only when the disease passes above the water level. To these may be added polyarteritis and dermatomyositis.

Diagnosis by Exclusion and Differential Diagnosis. It is not uncommon for a definite diagnosis of one of these diseases to be made only after long and careful study after ruling out other possibilities. A specific diagnosis may not be considered until after a patient has had at least one or two hospital admissions. Pathologists occasionally encounter cases in which the diagnosis is made only after a thorough postmortem histopathologic analysis. A clinical diagnosis of one of these disorders, in order to be accurate, will usually necessitate that a clinician utilize *all* available evidence at his disposal without necessarily relying upon a single test for any given diagnosis. Clinical laboratory procedures should be no substitute for sound medical judgment and experience.

Clinical Laboratory Features. The first clinical laboratory procedures to be noted are those of a general category, nonspecific procedures that may indicate altered substances found also in some disorders other than so-called "collagen disease." These other disorders have a predominant inflammatory component. The changes in this general category may be compared to the part of Boyd's iceberg found below water level. The most common abnormality found in most of these patients at some time during the course of their illness is that of serum protein abnormalities with the major change in the globulin fractions.

Presented at the 122nd Annual Meeting of the State Medical Society of Wisconsin, May 8, 1963, Milwaukee, honoring the Fiftieth Anniversary of Marquette University School of Medicine, Milwaukee.

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General Features. The common abnormalities are the acute phase reactants which includes the sedimentation rate, the C-reactive protein, and mucoproteins. An increased sedimentation rate is partially dependent upon altered and increased fibrinogen; the C-reactive protein may change before the sedimentation rate with improvement of a generalized inflammatory condition. Cortisone will allow a sedimentation rate to return to normal while C-reactive protein disappears from the serum. C-reactive protein found in the alpha-1 fraction has been shown to migrate with globulin fraction in free electrophoresis, and in zone electrophoresis using starch medium it is found in the gamma component. The increase of serum mucoproteins in some inflammatory conditions including the connective tissue disorders may be related to the connective tissue content of mucopolysaccharides which may be released upon injury. These acute phase reactants are nonspecific findings, but may be helpful in diagnosis. All of these procedures indicate some protein abnormality which may be variable, consisting of changes in one or all of these procedures.

Abnormal Proteins: Macroglobulins and Cryoglobulins. The macroglobulins have been recently reviewed by Rosen.[3] These abnormal proteins are precisely identified by the use of ultracentrifuge, but may be detected by the simple Sia test.[4] Stefanini and Dameshek's technic[5] is a simple and standardized procedure which may be used for evaluation of cryoglobulins, which appear as a white or milky precipitate in a tube of serum left in the refrigerator. Immunophoresis or precipitin testing using Ouchterlony plates is more specific, and because of its simplicity this method of study is becoming more common. It is not unusual in collagen diseases to find the serum electrophoresis pattern to indicate increased globulins, perhaps some decrease of albumin and a variable increase in the alpha-2 fraction of the gamma globulin. Unfortunately, only rarely will the electrophoretic pattern prove to be of real value. Because of quicker and more accurate analysis and separation of fractions, cellulose acetate electrophoresis is preferable to paper strip electrophoresis.

All of the collagen diseases may be associated with hyperglobulinemia. The rise in antistreptolysin-0 titer seen in patients with rheumatic fever usually correlates well with the rise in gamma globulin. Patients with well-advanced rheumatoid arthritis often have a serum showing a fall in albumin and a rise in serum globulin which is due primarily to an increase in the euglobulin and pseudoglobulin I fractions. An increase in both beta and gamma globulins is common in rheumatoid arthritis, whereas only the gamma globulin fraction may be increased in systemic lupus erythematosus. Correlated with the presence of abnormal proteins is the finding that the sera of some of these patients will indicate abnormalities in the cephalin cholesterol flocculation test, the thymol turbidity and zinc turbidity. Occasionally other abnormal liver function tests may be noted. False-positive serologic tests for syphilis may be seen in these diseases and the responsible "antibody," which has a molecular weight similar to that of other antibodies, is found both in the beta-2 and gamma components of serum.[6]

Serological Procedures: *Rheumatoid Disease.* The serological tests to be discussed may not be specific and may show a range of changes in the connective tissue disorders. The test for rheumatoid arthritis devised by Rose[7] and Waaler[8] has proved to be most helpful. The commonly accepted procedure today is a modification of Plotz's procedure with material available commercially as the Rheumatoid Arthritis Fixation Test (Difco). With this test a titer of 1:16 or higher is regarded as positive and significant. This test originated as a modification of the procedure introduced by Nicholls and Stainsby in 1931[9] in which a particular strain of nonhemolytic streptococci was agglutinated by the serum and synovial fluid of patients with rheumatoid arthritis. Dawson, et al.[10] showed that the phenomenon also occurred with hemolytic streptococci of group A. Because of this, many were convinced that his initial finding indicated that streptococci were the causative agent of rheumatoid arthritis. Waaler[8] first in 1940 and then Rose, et al.[7] in 1948 observed that sheep's red cells sensitized by amboceptor were also agglutinated by rheumatoid arthritis serum. Numerous modifications of the basic procedure have been made. Thulin[11] has concluded after careful studies that the streptococcal agglutinating factors and the rheumatoid factor react with distinct antigens and differ in their physicochemical properties. This author[12] suggests that there may be abnormalities of the en-

zymes involved in mesenchymal tissue metabolism resulting in abnormal proteins which become antigenic. Sheep cells were used by Heller, et al.[13] in which human gamma globulin (Cohn fraction II) is adsorbed onto tannic-acid treated sheep red cells which are then treated as antigen. Singer and Plotz[14] eliminated the sheep cells entirely and utilized instead antigen-coated latex particles. Agglutination of latex particles occurs in the presence of gamma globulins. This factor is a labile 19S globulin found in the euglobulin fraction which unites with 7S globulins in the procedures presently in use. More current work has found that the serum of patients with rheumatoid arthritis contains inheritable genetically determined factors described originally by Grubb,[15] Grubb and Laurell,[16] and recently reviewed by Fudenberg and Franklin.[17] Our present understanding is that one pair of chromosomes carries the genes determining the allelic factors Gm (a) and (b), so sera lacking Gm (a) are positive for Gm (b) and vice versa. Other factors, Gm (x) and (r), which may be present or absent in Gm (a +) individuals; both of these factors are absent in Gm (a —) individuals. Another factor is the InV, which is a combination of In for inhibition and V for the initial of a specific patient in whose sera this factor was identified. Large amounts of anti-Gm factors are found in the sera of rheumatoid arthritis patients. The Gm groups have been used widely by anthropologists and geneticists and have been useful in paternity evaluation, primarily in European laboratories. A variety of technics, some quite intricate, are used to determine the presence of these factors.

The types of procedures developed to demonstrate the rheumatoid factor are numerous and include the use of sheep, chicken and human red cells, tannic-acid treated erythrocytes and even alligator red cells, and latex and bentonite particles. Such cells or particles must be capable of uniform suspension and must be able to agglutinate with the serum of patients with rheumatoid arthritis after mixing under proper conditions.

Technics used to determine the presence and composition of the rheumatoid factor include chromatographic and enzymatic technics,[18] electrophoresis[19], precipitin tests [20, 21] and fluorescent procedures.[22] Some procedures are dependent upon agglutination, whereas others are based on agglutination-inhibition or precipitation. The rheumatoid factor has been found in the serum, urine[23] and the joint fluid,[24] but not in spinal fluid[23] of patients with active rheumatoid disease. Seifert[25] described four separate factors, two cold precipitated antigens and two antigens precipitated at room temperature. Several authors have recently reported that this rheumatoid factor consists of eight substances.[26]

Numerous authors have used the term "rheumatoid disease" when referring to rheumatoid arthritis. This is because of widespread tissue changes in this disease process as noted in other connective tissue disorders. There is much overlapping of the histologic features in the disorders under discussion. Patients with rheumatoid arthritis have had associated involvement with changes of progressive systemic sclerosis (scleroderma), dermatomyositis, polyarteritis, and lupus erythematosus. Commensurate with the histologic similarities are similar overlapping clinical laboratory procedures. Tests for rheumatoid factor, the lupus antinuclear factor, antithyroid factor, and other similar factors have been described in each of the disorders with false-positive procedures seen in 3 to 20 per cent dependent upon the series indicated. It is not unusual for some patients to have several positive serological procedures. Because it may not be easy to decide which positive factor is more significant, the physician must rely on his good judgment and experience. The underlying change is that of an abnormal blood protein. The rheumatoid factor has been described by Ball[27] in rheumatoid nodules, joint capsules, in healthy skin, and in tendons from patients with rheumatoid arthritis and not in controls. This author has reported that the bentonite flocculation test, because of greater sensitivity, is more often positive than the sensitized sheep cell agglutination test. The prognostic implications may be used in the quantitative dilution procedure for the rheumatoid factor with more active cases having a higher titer.[28] The titer usually decreases with clinical improvement. The variety of protein abnormalities seen in the blood of patients with rheumatoid disease suggests immunologic features as pointed out by Glynn and Holborow,[29] and Harboe.[30] The leukocytes and platelets of patients with rheumatoid disease have been shown to be coated with rheumatoid factor which is found in 90 per

cent of adult rheumatoid disease patients and 76 per cent of patients with juvenile arthritis (Still's disease) as noted by Hess and Ziff.[31] Mellors[32, 33] has described a cellular rheumatoid factor which is identified by a fluorescent immune technic. Fluorescein-labeled aggregated human gamma globulin was also identified in tissue sections of human lymph nodes and synovial membranes taken from patients suffering with rheumatoid arthritis. Mellors[32] and Russell[34] indicate that it may be likely that a rheumatoid-like factor may be related to tissue damage as suggested by Thulin.[12] Gajdusek[35] using an autoimmune technic with complement fixation extracts of normal tissue also suggests that such tissue damage may be a factor in pathogenesis of rheumatoid disease. The association of pulmonary fibrosis is well known in rheumatoid disease and Schroeder, et al.[36] found rheumatoid factor in significant amounts in the sera of 10 coal miners with round nodular fibrosis of the lung due to pneumoconiosis. Pulmonary fibrosis associated with rheumatoid disease was described by Ropes and Scully.[37] Their patient also had pericarditis and cirrhosis.

Vaughan and Butler[38] stated that the rheumatoid factor in rheumatoid arthritis is probably like the Wassermann antibody in syphilis, or the heterophil antibody in infectious mononucleosis. There is no evidence to date to suggest that the rheumatoid factor is a true antigen. Wohler[39] has shown that the rheumatoid factor has a carbohydrate content similar to that of normal 19S gamma globulin. Increased amounts of sialic acid in the serum of patients with rheumatoid arthritis is largely due to an increase in orosomucoid and haptoglobin as pointed out by Nettelbladt.[40] These changes are probably related to the increased serum mucoproteins seen in rheumatoid arthritis. McMillan[41] found that patients with acute rheumatoid arthritis excrete increased amounts of 3-hydroxyanthranilic acid in their urine. Bett[42] has confirmed this work and has added new information on tryptophan metabolism in rheumatoid arthritis. This metabolite is considered to be related to increased tryptophan catabolism. Grupper, et al.[43] in Paris, have confirmed the presence of 2, 5-hydroxyphenylpyruvic acid in the urine of patients with systemic lupus erythematosus, chronic discoid lupus, dermatomyositis, scleroderma, and rheumatoid disease. These authors suggest that the collagen diseases can be regarded as metabolic diseases due to some enzyme abnormality. Increased serum complement is found in the sera of the patients with rheumatoid disease.[44]

Systemic Lupus Erythematosus. The well-known and relatively common laboratory findings reported in systemic lupus erythematosus are those of anemia, both nonhemolytic and hemolytic, leukopenia, thrombocytopenia, increased sedimentation rate, often a positive serologic test for syphilis and urine abnormalities. After Hargraves[45] described lupus erythematosus phenomenon, it was quickly decided that this feature of the disease was essential for the diagnosis. The diagnosis of systemic lupus erythematosus was occasionally not made, except after finding the lupus erythematosus cell in clot preparations. Today, it is known that three factors are necessary to produce this cell: (1) a phagocytic cell, (2) nuclear deoxyribonucleoprotein, and (3) a serum or plasma antinuclear factor. This factor is found in a great majority of patients with systemic lupus erythematosus and, according to Alexander,[46] in 65 per cent of patients suffering with rheumatoid disease, in a small number of patients with polyarteritis, progressive systemic sclerosis and dermatomyositis, and in 4 per cent of 580 apparently healthy individuals. The nucleus of a leukocyte combines with the lupus erythematosus factor, a gamma globulin causing it to swell and lose its chromatin pattern after which it is ingested by a phagocytosing leukocyte which apparently destroys or removes the surrounding cytoplasmic material. The classical lupus erythematosus cell is then identified. With this cell the rosette is commonly associated. Numerous methods have been developed to identify this antinuclear material. These include in addition to the classical procedure of Hargraves[45] a variety of procedures, including an immunoelectrophoretic procedure of Atchley,[47] a precipitin reaction, Deicher,[48] latex nucleoprotein test, Dubois,[49] fluorescent antibody technic, Friou,[50] chromatographic and electrophoretic analysis, Fallet, et al.[51] hemagglutination studies, Lee and Epstein,[52] and the loose-body test, Van Soren,[53] and others. The material responsible for this test is a deoxyribonucleoprotein plus histone, Rothfield.[54] Nuclear material utilized for this test includes besides human red cells, sperm heads, and thymic lymphocytes. Deicher[55] has reported an anticytoplasmic

factor in the sera of patients with systemic lupus erythematosus. It was Bennett[56] who described intradermal hypersensitivity to leukocytes in the skin of patients with systemic lupus erythematosus. It has been suggested by Fallet[57] that the lupus erythematosus factor, a gamma globulin with a sedimentation coefficient of 7S, does not have a pathogenetic relationship with systemic lupus erythematosus, but is a byproduct of a disturbed immunologic mechanism. This lupus globulin-nucleoprotein factor with characteristics similar to those of antibodies has been found more consistently than any other specific factor in systemic lupus erythematosus. Because of the occasional appearance of autoimmune hemolytic anemia in some patients with systemic lupus erythematosus, it appears likely that immune factors other than the lupus erythematosus factor may explain some of the vagaries of this disease. Klemperer[58] has suggested that systemic lupus erythematosus not be labelled as a collagen disease because of recent elucidation of the nature of this disorder, and "characterized anatomically by a systemic implication of the intermediate substances, due to the deposition of degraded nucleoprotein."

Heimer[59] has shown that inhibitors of complement fixation were found in the sera of patients with rheumatoid disease, systemic lupus erythematosus and progressive systemic sclerosis. This factor is different from the rheumatoid factor found in rheumatoid disease and was not found in the sera of patients without connective tissue disease. It is interesting to note that Bridge and Foley[60] have shown evidence of the lupus erythematosus factor in newborn infants of mothers with systemic lupus erythematosus, thus indicating placental transmission.

The lupus erythematosus phenomenon has been found in pleural effusions and in synovial fluid aspirate, Ullmann and Rebuck.[65]

The urinary findings early in the course of systemic lupus erythematosus may be normal although Stevens[62] suggests that increased urinary gamma globulin may be an early sign of renal involvement. The classical findings are those of a "telescoped" sediment, which contains features found in many cases. The urinary changes have been adequately described by Miale[63] and Schreiner[64] and more recently by Muehrcke, Kark, Pirani and Pollak[65] in an extensive paper discussing "lupus nephritis." The urine contains elements found in the three stages of glomerulonephritis: the erythrocytes and erythrocyte casts of the acute stage, the oval fat bodies and fatty casts found in the subacute stage, and the broad casts found in chronic glomerulonephritis.

Gross[66] in a study of 118 patients with systemic lupus erythematosus found the following abnormal results in the indicated laboratory procedures: cephalin cholesterol flocculation—69%, thymol turbidity—54%, rheumatoid factor—15%, Coombs test—8%, serologic test for syphilis—29%, and an anticomplementary serologic test for syphilis —9%, positive treponema immobilization test—3%. Some patients with systemic lupus erythematosus and a significant percentage of their relatives have shown a variety of connective tissue disorders including agammaglobulinemia. A low serum gamma globulin may be found in these disorders.

Polyarteritis. The diagnosis of polyarteritis may not be easily made and may be associated with few significantly abnormal laboratory tests. The acute phase reactants are prominent with increased sedimentation rate, and the presence of C-reactive protein, and serum mucoproteins may be elevated. A patient with polyarteritis will often have acquired hemolytic anemia, which may be autoimmune with associated leukocytosis and a slight to moderate eosinophilia. The urinary findings are similar to those with systemic lupus erythematosus and membranous glomerulonephritis, with a telescoped sediment as described above. These features are in accord with the high incidence of renal involvement in systemic lupus erythematosus. Often the only method of specific diagnosis is a tissue biopsy indicating a necrotizing vasculitis, found in the skin or voluntary muscle, and perhaps incidentally in a surgically resected specimen. It is important to realize, however, that in some surgical specimens a localized vascular inflammation may represent only an isolated evidence of vascular inflammation and may not be a part of a generalized vascular inflammatory process. This type of vasculitis as well as others are not uncommon complications of the other so-called collagen diseases as pointed out in a review by Waksman.[67] Zeek[68] classifies this disorder with hypersensitivity angiitis, allergic granulomatous angiitis, rheumatic arteritis, and

temporal arteritis. She classifies this group of five inflammatory vascular lesions as "necrotizing angiitis." Both Symmers[1] and Rose and Spencer[69] were not able to distinguish the various types of vasculitis as described by Zeek.

Thrombotic Thrombocytopenic Purpura. Thrombotic thrombocytopenic purpura originally described by Moshchowitz,[70] is an acute febrile illness with clinical features consisting of hemolytic anemia, thrombocytopenic purpura, and fluctuating neurological disturbances. As expected, the laboratory features are thrombocytopenia and hemolytic anemia with increased sedimentation rate. Renal involvement is common and consists of urine abnormalities showing "telescoped" urinary sediment as described. Bone marrow aspiration smears may reveal normoblastic hyperplasia in keeping with the hemolytic process which also may produce a significant rise in the indirect and total bilirubin. The megakaryocytes noted in the bone marrow may be increased without specific cytoplasmic granulation. With anemia, there is an associated peripheral blood reticulocytosis and as expected the presence of urinary urobilinogen. There may be a positive Coombs test, a positive serologic test for syphilis, and evidence of abnormal blood proteins. It may be well in one of these cases to request a lupus erythematosus clot test, the latex antinucleoprotein test, the quantitative latex rheumatoid arthritis test, and the antithyroid test. One may be surprised at the number of these tests which will be positive. A tissue biopsy may allow a specific histologic diagnosis of this entity. The histologic section of an aspirated bone marrow clot revealing typical vascular changes was first reported by Cooper, et al.[71] Other authors have since made this observation. Although most of the reported cases noted in the literature have been of relatively short duration, a few cases have been reported of relative long duration.

Progressive Systemic Sclerosis (Scleroderma). Scleroderma, now better known as progressive systemic sclerosis may be associated with few abnormal laboratory tests. In the acute phase, there is often an increase of the sedimentation rate and hyperglobulinemia. Urine abnormalities are seen if there is renal involvement, which is common late in the disease process. The urine and serum may reflect the changes of oliguria and azotemia in a complicating acute renal failure as described in 5 of 31 cases noted by Piper and Helwig.[72] Fennell, et al.[73] in an immunohistochemical study noted that the tissues of patients with scleroderma contained antinuclear antibodies. This finding suggests a possible relationship to lupus erythematosus. Tuffanelli[74] found in the sera of patients with progressive systemic sclerosis the presence of lupus erythematosus cells and findings suggestive of rheumatoid arthritis and dermatomyositis. Rowell[75] found lupus erythematosus cells in the blood of 3 out of 16 cases of progressive systemic sclerosis. Tuffanelli[74] found lowered serum albumin with an increase of globulin and a 20 per cent incidence of false-positive serologic tests for syphilis. These authors suggest that because of these findings, some cases of progressive systemic sclerosis are due to autoimmune processes. Hall and associates[76] noted in 10 patients with progressive systemic sclerosis, the presence of fluorescent antinuclear activity in 8 with a positive test for the euglobulin fraction, a positive inhibition phase latex fixation test in 2, and a positive lupus erythematosus phenomenon in the serum of 1. Our last patient with scleroderma at the Sutter Community Hospitals had a negative lupus erythematosus test and a positive rheumatoid arthritis test. Also negative in this patient were the latex antinuclear test and the latex antithyroid test. Price and others[77] reported increased urinary excretion of kynurenine, acetyl kynurenine, 3-hydroxykynurenine, kynurenic acid after giving tryptophan to 3 patients with scleroderma. Price and Brown[78] suggested that progressive systemic sclerosis is related to an abnormal mineral metabolism with magnesium playing the major role. As previously indicated, the urines of these patients contain high levels of 2,5-hydroxyphenyl-pyruvic acid.

Abnormal stool findings have been reported by McBrien[79] and Rodnan and Fennell[80] due to intestinal involvement. Because some of these patients have had Hashimoto's thyroiditis, Tuffanelli[74] and Rowell[75] recommended the antithyroid test to exclude the possibility of this disease.

The urinary findings of systemic lupus erythematosus, polyarteritis and progressive systemic sclerosis are commonly referred to as a telescoped urinary sediment with red cells, leukocytes, fine and coarse granular

casts, red blood cell casts, and hyaline casts with proteinuria.

A variety of cases has been reported associated with agammaglobulinemia and several authors have noted in relatives of patients with progressive systemic sclerosis, the presence of agammaglobulinemia or other protein abnormalities with the sera of these patients showing evidence of the rheumatoid factor, the lupus antinuclear factor, and the antithyroid factor.

Dermatomyositis. Dermatomyositis is the rarest of the group of connective tissue disorders. In this disease, there is anemia, usually not hemolytic, a variable leukocytosis, an increased sedimentation rate, and a urine with abnormalities quite similar to those described above with proteinuria and hematuria.

Vickers[81] found in 5 patients with dermatomyositis elevations of the serum glutamic oxalacetic transaminase with a median range of 292 King units (range 124–485 King units). Serum glutamic pyruvic transaminase levels and creatine and creatinine determinations on the same patients revealed normal values. The finding of an elevated serum glutamic oxalacetic transaminase is in agreement with the findings of Siekert and Fleischer[82] and Moore, et al.[83] Vickers[81] was able to correlate the clinical improvement with the level of glutamic oxalacetic transaminase returning to normal levels. Any increase in clinical myositis was preceded by a rise in the serum glutamic oxalacetic transaminase. This is probably related to the voluntary muscle content of this enzyme as reported by Wroblewski.[84]

The correlation of dermatomyositis with malignant disease is well known since about 24 per cent of the cases are associated with malignancy. The relationship is obscure. Considering Burnet's clone theory,[85] could one consider that such a patient may have autoimmune or hypersensitivity alterations with altered body clones not recognizing "self" with resultant dermatomyositis and malignancy? Boynon[86] describes extensive vascular changes in a patient with dermatomyositis with urinary findings in direct proportion to the extent of renal involvement. Tuffanelli[74] describes 36 patients with dermatomyositis, of whom 7 had an elevation of the serum transaminase level. Bardawil[87] using immunohistochemical technics has reported antinuclear antibodies in the serum of patients with dermatomyositis, suggesting that this disease with rheumatoid arthritis and systemic lupus erythematosus has a common underlying mechanism initiated by sensitization against either intrinsic or extrinsic nucleoprotein.

Collagen Disease Interrelationships and Familial Studies. Many reports have appeared in the literature describing patients with good evidence of more than one of the collagen diseases. The critical examination of relatives of patients with one of the collagen diseases has shown that a significant percentage will have abnormal laboratory tests without clinical evidence of disease. These relatives have had positive rheumatoid arthritis tests, with demonstration of the lupus erythematosus cell phenomenon, and the presence of antinuclear antibodies and positive antithyroid test in addition to abnormal proteins including hypergammaglobulinemia and hypo- or agammaglobulinemia.[88, 89] Some of these reports have been noted above. A typical example is that of Wolf et al.[90] who described a patient with rheumatoid arthritis and acquired agammaglobulinemia with relatives having thrombopenic purpura, lupus erythematosus, rheumatic fever, rheumatoid arthritis, lupus-like syndrome, regional enteritis, bleeding tendency, hypergammaglobulinemia, and deficiency of immunoglobulins in high frequency. A thorough survey in such relatives may bring many surprises.

Many reports have appeared in the literature pointing out that thyroiditis is common in patients with one of these connective tissue disorders. Anderson[91] found thyroglobulin antibodies in the sera of 27 per cent of patients with collagen diseases in contrast to 12 per cent of controls with various other diseases. Of 506 patients with Hashimoto's thyroiditis, Becker[92] found 23.5 per cent with coexistent rheumatoid arthritis and related diseases. De Groot [93] found in the sera of 5 of 7 relatives of 2 patients with chronic thyroiditis the presence of circulating thyroglobulin antibodies. A variety of procedures has been developed to detect these antibodies. Perhaps the simplest test is the Thyroglobulin Autoprecipitin (TA) test. Witebsky has written extensively on the autoantibodies in chronic thyroiditis, and Milgrom and Witebsky[94] review many aspects of the immunologic and serologic alterations found in the sera of patients with connective tissue and autoimmune disorders.

Recommendations. Because of the basic protein abnormalities found in the collagen disorders, the initial laboratory procedures that may offer some suggestive clues are: an increased sedimentation rate, a positive C-reactive protein, increased serum mucoproteins, and abnormal gamma globulins. This latter finding may be noted as macroglobulins, cryoglobulins, or as abnormal liver function tests such as the thymol or zinc turbidity or cephalin cholesterol flocculation test. A positive serologic test for syphilis is not an uncommon finding. The abnormal protein factors which may be found are: the rheumatoid factor, the antinuclear factor seen in a variety of forms including the lupus erythematosus cell phenomenon, the antithyroid factor, and other similar factors which are "antibodies" to some body constituent. These factors may be identified by numerous technics, some intricate, others simple. Patients with dermatomyositis may have an increased serum glutamic oxalacetic transaminase indicating muscle damage. A telescoped urinary sediment may be found in these disorders having renal involvement.

With these procedures the physician must also take into consideration the presence or absence of anemia, leukopenia, leukocytosis, thrombocytopenia, and others. No matter how elaborate the laboratory procedure, the physician must depend upon his experience and judgment for a thorough evaluation of his patient. A single test, no matter how positive, will not make the diagnosis for the physician. The first approach to the diagnosis of a collagen disorder must be an exclusion or "ruling-out" of other possible disease entities. Once this general approach is accomplished a specific diagnostic approach is warranted.

It is understood that a substantial or specific diagnosis may not be made until a surgical biopsy is done. Some diagnoses are not made until autopsy analysis.

The practical laboratory procedures most likely to be of value are indicated with the following diseases:

Rheumatoid disease—Rheumatoid arthritis (RA) latex fixation test.

Systemic lupus erythematosus—The lupus erythematosus cell phenomenon and the latex antinucleoprotein test.

Polyarteritis—No specific test, perhaps eosinophilia.

Thrombotic thrombocytopenic purpura—Evidence of hemolytic anemia with a positive Coombs test, and thrombocytopenia. (Variable and transient neurological disturbances.)

Progressive systemic sclerosis—No specific test, (abnormal magnesium metabolism?)

Dermatomyositis—Increased serum glutamic oxalacetic transaminase.

Summary. Various aspects of the laboratory diagnosis of collagen disease are considered including rheumatoid disease, systemic lupus erythematosus, polyarteritis, thrombotic thrombocytopenic purpura, progressive systemic sclerosis, and dermatomyositis. General underlying blood protein abnormalities are seen in many of these disorders with a few tests considered to be of more specific character. The abnormal proteins (principally the gamma globulin fractions) found in these disorders are considered to be similar in relationship to the disease under question as Wassermann reagin is related to syphilis and as the heterophil antibody is related to infectious mononucleosis. The more specific tests outlined are the rheumatoid arthritis test (quantitative), the lupus erythematosus cell phenomenon, the detection of antinuclear "antibody," and antithyroid "antibody." Some patients with these connective tissue disorders will have in their urine increased amounts of 3-hydroxyanthranilic acid, a normal intermediate of tryptophan metabolism, and 2,5-dihydroxyphenyl-pyruvic acid, not found in the urine of normal subjects.

An extensive amount of experimental and clinical research is being conducted and further elucidation of these diseases is to be expected perhaps indicating a more distinct relationship with the autoimmune or hypersensitivity diseases. An excellent review in this area is given by Waksman.[95]

Many patients with one collagen disorder may occasionally develop another of these disorders so that precise classification may not be easy. The relatives of many patients having a connective tissue disease can be shown to exhibit serum protein abnormalities with a significantly high percentage of involvement with similar disorders.

A bibliography of this article may be obtained by writing to the Journal.

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

Oral Hypoglycemic Agents

By DEANE N. CALVERT, Ph.D.
Milwaukee, Wisconsin

■ THE DISCOVERY of insulin in 1922 appeared at first to have solved all the problems associated with diabetes mellitus. Indeed, the contribution to the therapy of diabetes by insulin is difficult to exaggerate. However, the nagging dissatisfaction with the necessity for parenteral administration and a growing body of evidence that all types of diabetes mellitus may not be due to insulin deficiency has led to a continuous search for agents as sulfadiazine and sulfisomidine.

The search has been modestly rewarded by the introduction into therapy of several compounds whose oral administration leads to reduction of blood glucose.[1, 2] Chemically, these agents can be divided into two groups: the sulfonylureas and a biguanide. The sulfonylureas are closely related to the sulfonamides whose members include such outstanding pharmacological agents as the carbonic anhydrase inhibitor diuretics (for example acetazolamide) and such chemotherapeutic agents as sulfadiazine and sulfisomidine.

A. The sulfonylureas (tolbutamide, chlorpropamide). When administered orally, these compounds produce a fall in blood glucose in intact animals, in incompletely diabetic animals, in nondiabetic humans, and in some diabetic persons. The mechanism whereby they produce this effect is fairly well established but the complete story is not yet known. It is a tribute to the ingenuity of the investigators in this area that our knowledge of the subject has advanced to its present state when we consider the numerous complex, interdependent and inadequately understood factors which influence blood glucose concentration. It is clear that these compounds stimulate the release of insulin from the beta cells of the islets of Langerhans in the pancreas. This phenomenon is spoken of as "beta cytotropism." Evidence that this phenomenon occurs includes an increase in the amounts of an insulin-like material found in the pancreatic venous blood following the administration of these agents and histologically demonstrable degranulation of the beta cells following administration of the drugs to animals. It has also been observed but is less widely accepted that the compounds reduce hepatic glucose release. The mechanism of this effect is probably partially via a direct effect upon the hepatic cell and partially through the insulin released from the pancreas. Elucidation of the exact mechanism of the inhibition of glucose release from the liver by the sulfonylureas must await a clear demonstration of the direct effects of insulin on the liver.

B. The biguanide (phenformin). Because of the toxic effects of the biguanide, Synthalin, which was introduced as an oral hypoglycemic agent in 1926, this group of agents has a bad reputation among physicians. However, the introduction of phenformin has presented a useful compound for therapy of diabetes mellitus. This drug differs from the sulfonylureas in that while oral administration will reduce the blood glucose in the diabetic human, in orally tolerated doses nondiabetics do not respond with hypoglycemia. The mechanism of hypoglycemia in the diabetic is not understood. It is clear, however, that it does *not* involve release of insulin from the beta cells of the pancreatic islet tissue but the presence of some insulin in the blood appears to be essential for the hypoglycemic effect.

On the basis of the mechanism whereby the drugs produce their hypoglycemic effects,

FOR CORRECTION SEE p. 399

it becomes obvious which types of diabetic patients will be most effectively treated with these drugs. Since the sulfonylureas require the presence of insulin in the pancreas, those patients with the so-called adult onset type of diabetes are most effectively treated with these drugs. Unfortunately, "secondary failure" has been observed in a large percentage of those individuals undergoing long term treatment with the sulfonylureas. While it is undoubtedly true that a few patients do develop resistance to the hypoglycemic effects of these compounds, it has been found that in a very large percentage of the failures, disregard of the prescribed diet has contributed heavily to the failures. Treatment of such patients with insulin sometimes restores their response to the sulfonylureas.

Juvenile diabetics cannot be successfully treated with the sulfonylureas since their pancreata contain little or no insulin. On the other hand, the biguanides can be effectively employed in the juvenile diabetic to reduce the daily dosage of insulin required for control of the hyperglycemia. It is also claimed that the combination of the sulfonylureas with the biguanide is of value in those patients inadequately controlled by the sulfonylureas alone.

The oral hypoglycemic agents are singularly low in toxic effects. Both tolbutamide and chlorpropamide have produced a few cases of blood dyscrasias and chlorpropamide is reported to have produced a few cases of jaundice. Since the sulfonylureas will lower the blood sugar in the normal individual, they represent a potential source of accidental poisoning especially in children. Such an accident has recently been reported.[3] The only toxic effect reported for phenformin is gastrointestinal irritation. This necessitates dividing the daily doses and keeping them as low as possible.

The oral hypoglycemic agents represent a significant contribution to medicine since they are a first step on the way to freeing the diabetic from his daily insulin injection. Moreover, they have contributed to our better understanding of the mode of action of insulin at the cellular level.

REFERENCES

1. Duncan, L. J. P., and Baird, J. D.: Compounds administered orally in treatment of diabetes mellitus, Pharmacol. Rev. 12: 91–158 (Mar.) 1960.
2. Levine, R., and Berger, S.: Orally active hypoglycemic substances and rationale of their use, Clin. Pharmacol. and Therap. 1: 227–246 (Mar–Apr) 1960.
3. Youberg, D. R.: Accidental ingestion of chlorpropamide, New England J. Med. 263: 1130–1131 (Dec 1) 1960.

WARNING ON DRUGS FOR URINARY TRACT IRRIGATION

Commissioner of Food and Drugs George P. Larrick on June 13 issued the following warning to doctors, hospitals and drug distribution outlets who may use or sell drugs for urinary tract irrigation:

> Stop use or sale of the drug Renacidin, manufactured by the Guardian Chemical Corporation, Long Island City, New York. The safety of the drug is questioned by a number of doctors who have used the product.

The product is being recalled by the manufacturer at FDA's request.

The warning was prompted by a report in the *Journal of Urology* for March 1963. The authors of this report stated in part as a conclusion: "Severe complications resulting in death can occur during lavage therapy with renacidin for renal calculi . . ."

Commissioner Larrick said the product is a "new drug" under the Federal Food, Drug, and Cosmetic Act and has never received a safety clearance as required by the Act.

The product is described on its label as a mixture of "edible, multi-valent organic acids selected from the group: gluconic, citric and malic and acid salts of same."

MEMO FROM STATE BOARD OF HEALTH

Section H 26.074 of the Wisconsin Administrative Code relating to formula and fluids has been amended by adding a section (7) as follows:

> "(7) READY-TO-USE FORMULAS. Terminal sterilization and refrigeration shall not be required for ready-to-use infant formulas packaged and sterilized in sealed containers when such formulas are approved by the board for use in accordance with the methods recommended by the manufacturer."

At its meeting on June 7, 1963, the State Board of Health approved for use under the provisions of this section Ross Laboratories' Similac 20 and 5% Glucose Water and Mead Johnson Company's ready-to-use 20 Calorie per fluid ounce formulas designed for the Beniflex System.—JAMES L. WARDLAW, JR., M.D., *Director*, Bureau of Maternal and Child Health.

THE PRESIDENT'S PAGE . . .

Significant Meetings

■ SURVEY implementation committee physicians, J. C. Griffith, C. J. Picard, L. W. Schrank, P. B. Mason, J. H. Houghton, R. P. Sproule, G. F. Tegtmeyer, R. C. Callan, (H. W. Carey absent due to injuries), and W. J. Egan, held their first organizational meeting on June 21 in Milwaukee.

J. C. Griffith was chosen committee chairman, J. H. Houghton, vice-chairman, and G. F. Tegtmeyer, secretary. A plan of approach was developed with the next meeting scheduled for July 13–14 at which time the entire report, with additional information and background material, was to be discussed.

A.M.A. ANNUAL convention, Atlantic City, June 16–20. This was my first experience of attending only to the operations of our parent body. I was very pleased and greatly encouraged to learn how superlatively well the total convention was handled.

L. O. Simenstad, M.D., was elected from a slate of exceptionally strong aspirants to the A.M.A. Board of Trustees.

His election, evidently the first one from a smaller city like Osceola, attests to the splendid work Doctor Simenstad has been doing for our Society.

Miss Alice Budny, Milwaukee, president, American Association of Medical Assistants, was presented to the House of Delegates.

The Woman's Auxiliary to the A.M.A. contributed greatly in making the national meeting so successful. The Wisconsin Auxiliary contributed $5,976.67 of the total national woman's auxiliary gift of $273,410.35, which included $227,066.54 in unrestricted funds for medical schools and $46,343.81 for the student loan fund—the first year in which the national auxiliary has given to the student loan fund.

W. J. Egan M.D.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

JULY 1963
Vol. 62 No. 7

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

A Remedy

■ FOR REASONS best known to himself, Nelson Rockefeller, governor of the state of New York, asked for, and received from a compliant legislature, passage of a bill licensing chiropractors. Thus, the Empire State succumbed to the pressure and political leverage exercised by the cultists, and left Massachusetts and Alabama as the only states in the Union without chiropractic licensure.

As fellow victims of the ambition of chiropractors, the people of Wisconsin can offer sympathy to the people of New York. We know how a seemingly innocuous law, passed under the pretext of limiting quackery, can actually be used to extend quackery and to dignify its practice. As a direct result of the Wisconsin law, we have a growing horror at Mt. Horeb, where an enterprising cultist is building a combination seminary–motel–mountebank center for the greater glory of chiropractic and avarice.

In Wisconsin, however, the chiropractors had to go it alone. They accomplished their purpose without the active assistance of our governor. In New York, the cultists had a number of state senators and assemblymen in their pockets. They also had the very urgent support of Rockefeller, who not only sponsored the licensure law, but virtually insisted on its passage.

Why he placed the authority of his office behind a measure that clearly contravenes the health interest of the people of his state can only be guessed. If the pattern of chiropractic conspiracy held true in this instance, guessing Rockefeller's motives isn't too difficult. It is well known that when chiropractic organizations have money to spend, they spend it liberally. Politics in New York—or anywhere else, indeed—are not so simon-pure that we can rule out the possibility that well-placed campaign contributions generated the steam to force passage of a bill that members of the legislature knew to be harmful.

Now that the damage is done—now that 48 of the 50 states have given legal respectability to chiropractic cultists, the time has come to start the pendulum swinging in the opposite direction. Laws can be repealed, and licensure laws are no exception. If chiropractors can get themselves licensed, they can also be de-licensed, and the medical profession ought to start action now to reverse the licensure laws.

In the years since chiropractors have been licensed to practice, and in the states in which their practice has legal sanction, enough evidence of their damage can be accumulated to present a strong case against them. In this day of scientific sophistication, it is inconceivable that the pseudo-scientific clap-trap of chiropractic should not impress legislators with its inanity. In this era when a prevailing government philosophy tries desperately to protect the fools among us from their own folly, it is ironic that one of the most dangerous health lunacies should be legally condoned.

As demonstrated in New York, facts alone won't convince legislators; they require the reinforcement of political pressure. The medical profession can muster the facts against chiropractic, but it must also focus its political weight to accomplish its goal.

Wisconsin is famous for its advanced political action—for its progressive laws and institutions. It is fitting that we start the ball rolling against chiropractic and return these cultists to the shabby limbo of quackery where they belong.—D. N. G.

Hazards of Responsibility

You, Doctor, are responsible for the great advance in medical care. In congratulating yourself on the lessened morbidity and mortality of your patients, however, don't forget you are also responsible for the hazards of employing such potent therapy. You can't transfer this responsibility to the pharmaceutical industry as certain professors have attempted to do in testifying before the Senate Subcommittee. You may, however, see this responsibility transferred to Federal or state government by default unless you exercise your franchise as a citizen and become more active politically.—GEORGE E. FARRAR, JR., M.D., in *Resident Physician*, Feb. 1963.

Physicians, Then and Now . . . REPRINTED WITH

PERMISSION, FROM THE COLUMN "JAUNTS WITH JAMIE" IN *MILWAUKEE SENTINEL*, MAY 13, 1963

ONCE AGAIN it's time to take to the open road. Soaking up tradition and visiting historic spots along the way adds much to touring interest. One of the most exciting of the State Historical society's Mississippi river sites at Prairie du Chien is the Museum of Medical Progress.

It would take a Paul de Kruif to do justice in words to the exhibits which trace the progress of Wisconsin medicine from the roots and herbs of the Indians to medicines of the space age.

Fortunately, few words are needed. A guide leads you along the trails of medicine which, in many instances, reach the top of the mountain. The exhibits, dioramas and animated displays, such as the heart and circulatory system, reveal the adventure that has been medicine since the days of Hippocrates.

The guides also take you along what the museum's curator, Gordon Peckham, calls "the side roads of quackery and superstition."

FRONTIER MEDICINE began with military surgeons who were followed by the "doctor on horseback" whose saddle bags were fitted with instruments, bottles of medicines and pills.

Then came the era of the "horse and buggy doctor," which began about the time of the Civil War and lasted through the first decade of this century. One pioneer Merrill doctor developed his own vehicle by converting a bicycle into a tricycle that would ride the railroad tracks. He was able to pedal rapidly to logging camps and farms along the tracks. The vehicle was a real time saver.

In those prehospital days, the doctor's office, usually in his home, was also his surgery. Transporting a sick or injured patient was always a problem, so more often than not the pioneer surgeon performed his emergency operations on kitchen tables by candle or lamp light.

THE MUSEUM was opened two years ago as a memorial to Dr. William Beaumont, a military surgeon on Col. Zachary Taylor's staff at Fort Crawford, Prairie du Chien, in the early 1830's.

One of the outstanding exhibits has to do with Dr. Beaumont's experiments in the digestive processes. Through a hole in the subject's abdomen. Beaumont actually used the man's stomach and gastric juices for his tests.

Fittingly, the Medical Museum of Progress is the reconstructed Fort Crawford hospital where Beaumont practiced. The museum, overlooking the Mississippi, is owned by the State Medical society and operated by the State Historical society.

The vivid and dramatic portrayal of where the doctor has been, where he is and where he is going is "must" for the entire family when visiting Prairie du Chien. This house of hope is well worth a special trip.

the wisconsin medical journal

VOLUME 62/NUMBER 8 AUGUST 1963

Rabies in Wisconsin

By ALFRED S. EVANS, M.D., M.P.H.
Madison, Wisconsin

Summer brings a real rabies problem to many physicians. Knowledge of the proper management, particularly of recent changes in the use of rabies immune serum, requires wide dissemination. The following article has been specially prepared for Wisconsin physicians.

■ RABIES constitutes a continuing problem in Wisconsin. The experience of the State Laboratory in the past two years is summarized in Table 1.* No human cases occurred although human exposure was involved in almost all animals sent in. The cat is now equally as important in rabies as the dog among small domestic animals; and large farm animals such as the cow, sheep, and horse not infrequently contract rabies, presumably as a consequence of a wild animal bite. The bat also posed a real problem as about 12 per cent were rabid.

The skunk is a notoriously rabid animal in Wisconsin and all physicians should give immune serum and vaccine immediately after a human has been bitten. Over the five years prior to 1961 about 85 per cent of all skunks submitted were positive; routine examination was discontinued at that point because for practical purposes the biting skunk could be regarded as rabid. The figure of 62 per cent positive in 1961–1962 shown in Table 1 may well reflect the fact that only selective examination of skunks has been done rather than represent a real decrease in skunk rabies. The fox also has rabies on occasion and a fox bite should be regarded with concern. Small wild animals like squirrels, mice, hamsters, and chipmunks have very rarely been found rabid, nor has the rabbit. In addition to the results given in Table 1, 551 animals have been examined from January to July 1963, of which 32 or 0.6% have been positive.

At the present time the failure to identify Negri bodies in the suspected animals brain does not exclude the possibility of rabies because up to 10 to 20% of Negri negative brains may produce rabies after inoculation into mice. As this procedure in mice may take up to 2 to 3 weeks, the physician may receive the results too late to carry out an effective vaccination program. Under these circumstances he must decide earlier what to do, basing his decision on the severity of the bite, the behavior of the animal, whether the attack was provoked or not, and the frequency with which rabies occurs in that animal species. Frequently, as with the bat, the biting animal may escape. Further laboratory work with fluorescent antibody technique offers promise of earlier, more sensitive diagnosis. It will be used when sufficient experience has accumulated in its methodology to be sure of the results. Performed as rapidly as the examination for Negri bodies, it may pick up cases which are

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* Appreciation is expressed to Mr. Donald Nelson, Chief of the Virus Section and Miss Ethel Trenary, Head of the Rabies Diagnostic Unit, State Laboratory of Hygiene, for compiling the data.

TABLE 1—*Rabies in Wisconsin, 1961–62*

Animal	1961		1962		Total		
	No. Done	No. Pos.*	No. Done	No. Pos.*	No. Done	No. Pos.	% Pos.
Dog	131	4	157	8	288	12	4.2
Cat	102	6	139	11	241	17	7.0
Bat	37	2	59	5	96	7	11.9
Cattle	34	7	31	4	65	11	16.9
Skunk	16	7	16	13	32	20	62.5
Fox	17	1	10	2	27	3	11.1
Horse	0	0	3	1	3	1	33.3
Sheep	4	0	4	2	8	2	25.0
Mouse	61	1	76	0	137	1	0.7
Other**	322	0	404	0	726	0	0
Total	724	28	899	46	1623	74	0.4

*Positive: Negri bodies found or positive by fluorescent antibody or mouse inoculation.
**Other: Number examined and found to be negative for rabies in 1961 and 1962.

Badger	1	Hamster	126	Rabbit	85
Bear	1	Hawk	1	Raccoon	48
Bobcat	1	Human	1	Rat	67
Chinchilla	1	Mink	4	Shrew	1
Chipmunk	63	Mole	21	Squirrel	175
Crow	2	Monkey	6	Swine	2
Duck	1	Muskrat	39	Vale	4
Gopher	36	Oppossum	6	Weasel	5
Guinea pig	13	Parakeet	1	Woodchuck	10

Negri-negative because smaller virus aggregates are identifiable than in the Negri inclusion body. In the State Laboratory five rabies positive have been identified by this method in the past two years in which Negri bodies were not seen. Additional laboratory personnel and longer experience are needed before the fluorescent technique can be routinely used in Wisconsin.

Prevention of Rabies. Increasing emphasis is being placed on the use of antirabies serum in addition to vaccine in the prevention of rabies following exposure. In the World Health Organization Fourth Report on Rabies (WHO Technical Report Series No. 201, 1960) immediate serum treatment followed by a course of vaccine is recommended for both mild and severe bites by wild animals such as the wolf, jackal, fox, bat, skunk, and so forth. Immediate serum treatment is also recommended for *all* types of severe exposures (multiple, or face, head, finger, or neck bites) irrespective of the type of animal or its condition at the time of exposure; vaccine is given in addition if clinical or laboratory evidence of rabies is found or develops. These (WHO) recommendations are presented below.

A critical review emphasizing the greater usefulness of antiserum over vaccine in the prevention of rabies is presented in a paper by E. A. Hildreth in the May 1963 issue of the *Annals of Internal Medicine.* In brief his evidence consists of (1) the lack of controlled trials establishing vaccine effectiveness; (2) that 8 of 15 persons dying of rabies in the United States from 1958 through 1963 had received vaccine treatment whereas there have been no known instances of deaths in those who received antiserum early enough and in doses currently recommended; (3) experimental studies in hamsters by Koprowski have indicated that the standard phenolized vaccine instituted 24 hours after exposure failed in all instances to protect exposed hamsters whereas one injection of antiserum exerted a definite protective effect when the animal had been infected 24 hours previously with street virus.

In the United States hyperimmune serum is made by Lederle Company and duck embryo rabies vaccine is made by Eli Lilly & Co. Under the circumstances outlined by the World Health Organization one should not wait for results from the State Laboratory of Hygiene as the effectiveness of antiserum is limited primarily to the first 24 hours after exposure. The State Laboratory will continue to process all specimens promptly and to report those positive by telephone but we will be unable to have such results available within the period that rabies antiserum will be effective.

WHO Recommendations for Treatment and Prevention. The following are excerpted from WHO Technical Report Series No. 201, "Expert Committee on Rabies," Fourth Report, 1960.* The paragraph designations are those used in the pamphlet.

6. Prevention of Rabies in Man

6.1 Summary of developments since the third report.

Results reported from several institutes have confirmed the effectiveness of the combined serum and vaccine treatment of exposed human beings, and the Committee wishes to emphasize that this is definitely the best method now available.

The phenomenon of interference with the antibody response to vaccine by antirabies serum has been further demonstrated and possible means for avoiding it have been developed. Slight revisions in the Guide for Post-Exposure Treatment (section 6.3) have been made in view of these findings.

* Obtainable for $.30 each from Columbia University Press International Documents Service, 2960 Broadway, New York 27, N. Y.

The development of an inactivated virus avian embryo vaccine (duck embryo) shown in experimental work to contain only minimal amounts of the factor or factors responsible for allergic encephalitis as compared with nervous tissue vaccines similarly tested should help to reduce post-vaccinal nervous system reactions, and it has been shown that antihistamines can reduce the incidence of serum sickness following the use of serum.

Attempts to reduce the number of doses of vaccine have been unsuccessful. The factors involved in pre-exposure immunization with a subsequent booster dose of vaccine at the time of exposure have been further clarified and recommendations amended.

6.2 Local treatment of wounds.

All bite wounds and scratches by animals should receive immediate local treatment. For bite wounds, thorough cleansing with soap or a detergent and flushing of the wound may be supplemented by the judicious use of concentrated nitric acid in puncture wounds where the site permits. Where possible, bite wounds should not be immediately sutured.

In those patients the nature of whose exposure requires the use of serum (see section 6.3) a part of the serum dose should be infiltrated into the tissue beneath the wound, when this is feasible. The value of local application of powdered antirabies gammaglobulin into the bite wound is being studied.

The application of ordinary antiseptics and antibiotics or antitetanus procedures should follow the local treatment recommended above, when indicated.

6.3 Guide for specific post-exposure treatment.

The accompanying guide (Table 2) and explanatory notes represent a slight modification from similar charts published in previous reports of the Committee. These explanatory notes apply to the guide (Table 2).

The general principles are that in mild exposures a course of vaccine following the above-recommended local treatment is sufficient, whereas following severe exposures,

TABLE 2—*Guide for Specific Post-exposure Treatment of Rabies from Expert Committee on Rabies, WHO, 1960*

Nature of Exposure	Biting Animal*		Recommended Treatment** (in addition to local treatment)
	At Time of Exposure	During Observation Period of 10 Days	
I. No lesion; indirect contact	Rabid	--------	None
II. Licks:			
(1) unabraded skin	Rabid	--------	None
(2) abraded skin, scratches and unabraded or abraded mucosa	(a) healthy	Clinical signs of rabies or proven rabid (laboratory)	Start vaccine at first signs of rabies in the biting animal
	(b) signs suggestive of rabies	Healthy	Start vaccine immediately; stop treatment if animal is normal on fifth day after exposure
	(c) rabid, escaped, killed or unknown	---- --	Start vaccine immediately
III. Bites:			
(1) mild exposure	(a) healthy	Clinical signs of rabies or proven rabid (laboratory)	Start vaccine at first signs of rabies in the biting animal
	(b) signs suggestive of rabies	Healthy	Start vaccine immediately; stop treatment if animal is normal on fifth day after exposure
	(c) rabid, escaped, killed or unknown	--------	Start vaccine immediately
	(d) wild (wolf, jackal, fox, bat, etc.)	--- ----	Serum immediately, followed by a course of vaccine†
(2) severe exposure (multiple, or face, head, finger or neck bites)	(a) healthy	Clinical signs of rabies or proven rabid (laboratory)	Serum immediately; start vaccine† at first sign of rabies in the biting animal
	(b) signs suggestive of rabies	Healthy	Serum immediately; followed by vaccine; vaccine may be stopped if animal is normal on 5th day after exposure
	(c) rabid, escaped, killed or unknown	- ---- -	Serum immediately; followed by vaccine†
	(d) wild (wolf, jackal, fox, bat, etc.)		

*This schedule applies equally whether or not the biting animal has been previously vaccinated.
**See explanatory notes.
†Course of vaccine to be followed by supplemental doses of vaccine of non-nervous tissue if possible, 10 and 20 days after the last usual dose.

and in all cases of unprovoked wild animal bites, antirabies serum together with vaccine should be employed. As with vaccine alone, it is important to start combined serum and vaccine treatment as early as possible after exposure. Serum should be administered in a single dose (not less than 40 International Units per kg. of body weight) at the start of the treatment, followed by a course of not less than 14 daily doses of vaccine. In all cases where serum is followed by a full course of vaccine it is suggested that two supplemental doses of vaccine be administered at 10 and 20 days following the completion of the usual vaccine schedule. Where possible, these supplemental doses should be with a vaccine of non-nervous-tissue origin.

Sensitivity to serum should be tested before serum is used.

It is fully recognized that this table is only a guide and in certain situations specific conditions may warrant modifications, e.g., exposure, especially in young children or where a reliable history cannot be obtained, and particularly in areas where rabies is known to be enzootic even though the animal at the time of exposure is considered to be healthy. Such cases may justify treatment immediately in a modified way. Possible modifications would be that, following local treatment of the wound as described above, a single dose of serum or three doses of vaccine at daily intervals, and no further vaccine, be given as long as the animal stays healthy for 10 days following exposure.

Another example of a local situation in which a modified interpretation of these recommendations may be indicated is that of rabies-free areas where frequent exposures to animal bites are encountered. In such localities, adequate laboratory and field experience indicating no infection in the species involved may justify the local health authorities in recommending no specific antirabies treatment.

6.3.1 Complications of antirabies treatment.

The Committee points out that reactions to antirabies horse serum, even though the serum is concentrated and purified, do occur to approximately the same degree as with other sera of animal origin. An immediate anaphylactic type of reaction should be avoided by careful questioning about past history of allergy and the routine use of an intradermal or ophthalmic test for sensitivity. In case of a positive sensitivity test, the usual precautions of desensitization should be followed.

The incidence of serum sickness which is encountered following administration of serum can be reduced by the concomitant administration of antihistamine drugs in large, sustaining doses for several days after treatment.

6.3.2 Nervous-tissue vaccine.

It is known that the incidence of neuroparalytic accidents following a course of nervous-tissue vaccine varies from one country to another. The Committee recognized that it is impossible at present to determine the basis for these apparent differences, but any consideration of the matter must take into account such host factors as the population involved, and the physiological state of the individual, species of animals used in vaccine production, method of inactivation and dosage schedule. The incidence of these complications is high enough in certain areas of the world to indicate the need for further efforts to eliminate them.

When neuroparalytic accidents or premonitory symptoms indicating their development occur, the following possible procedures are suggested, although at the present time, no definite scientific evidence is available as to their effectiveness. If, in view of the degree of original exposure, the amount of immunization already obtained is considered to be adequate, all further vaccine administration may be discontinued; if further immunization is indicated, vaccine prepared from non-nervous-tissue should be used in lieu of brain-tissue vaccines. In either instance the use of such products as corticosteroids and ACTH should be considered.

Inactivating agents used in the production of killed vaccine should be safe for man and used in a concentration which will produce minimum reaction in the vaccinated individual.

6.3.3 Vaccines prepared from avian embryos.

Persons known to be sensitive to egg protein should not ordinarily be given vaccines of avian origin without proper precautions. Chicken-embryo and duck-embryo vaccines have shown no deleterious effect in man except for local reactions, including adenopathy.

6.4 Immunization of man against rabies before exposure.

Rabies prophylaxis in man has long been a special problem when it involves particular groups of individuals with unusual risks of repeated exposure, such as veterinarians, dog handlers, field naturalists, laboratory workers, and others. In these groups, repeated exposure means repeated treatment, thus increasing the possibilities of severe reactions to the vaccine, especially those involving the central nervous system.

There are now two types of vaccine available which are almost devoid of encephalitogenic properties which may be used for prophylactic immunization of man—namely, the duck-embryo and the HEP chicken-embryo vaccine. It is suggested that the schedule of immunization consisting of three intradermal doses of these vaccines be given five to seven days apart followed by a booster dose administered one or more months (preferably two to six months) after the last dose of vaccine. If the individual continues to work under risk, he should be revaccinated with a similar booster dose every two to three years. However, results obtained in field trials indicate that regardless of the schedule of immunization, antibody response does not occur in all the vaccinated individuals. If a prophylactic immunization is carried out with these vaccines, it is essential that a detectable antibody response should be checked on a serum sample obtained one to two months after the completion of vaccination. Booster doses can be repeated until antibody is detectable. (Antibody determinations for rabies are *not* presently available in the State Laboratory of Hygiene).

It was also found that a single injection of any potent antirabies vaccine, i.e., chicken-embryo, duck-embryo or nervous-tissue vaccine, given to an individual who had had antirabies treatment in the past resulted in a prompt and significant antibody rise. It is therefore recommended that in case of mild exposure of an individual who has demonstrated an antibody response to antirabies vaccination received in the past, a single booster dose of vaccine be given. In case of severe exposure the Committee feels that the usual post-exposure treatment (section 6.3), consisting of administration of antirabies serum and a full course of vaccine, should be given.

DEATH FOLLOWING CAROTID SINUS PRESSURE

Greenwood, Richard J. and Dupler, Donald A., Graduate Hospital of the University of Pennsylvania, Philadelphia, Pa., *Journal of the American Medical Association* 181:605 (Aug 18) 1962.

The authors report 2 patients who died suddenly due to carotid sinus stimulation. One patient, a 66 year old man with pneumonia and congestive heart failure, probably also was suffering from an overdosage of digitalis when he died during carotid sinus pressure. The second patient, a 70 year old woman with known coronary artery disease and hypertension, was admitted to the hospital with acute posterior myocardial infarction. Several hours after her admission she was found to have an apical pulse of 180 per minute. While the physician was listening to the heart, he applied carotid sinus pressure. The heart stopped immediately, and the patient could not be resuscitated.

Although the etiologic role that carotid sinus pressure played in the deaths of these 2 patients is not definitely established, certain precautions are indicated in its use: (1) bilateral carotid sinus pressure should never be used; (2) carotid sinus pressure should be limited to the briefest effective time, usually five seconds or less; (3) except in emergencies, electrocardiographic monitoring should be used for all patients over the age of 40 years and when possible for all patients; (4) when electrocardiographic monitoring is not used, constant auscultatory monitoring is mandatory; (5) carotid sinus pressure should be avoided when the blood pressure is below 100 mm. Hg systolic; (6) the procedure should be used cautiously when the patient is receiving cardiac drugs; (7) elderly patients should not be treated "rashly" with this method, especially those with arteriosclerosis; and (8) the procedure should be monitored with both EKG and EEG if carotid artery disease is suspected.

GASTRIC SURGERY

By W. B. GALLAGHER, M. D., F. A. C. S.

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■ MOST STOMACH surgery, aside from that for pyloric stenosis in infancy, is for complicated or persistent peptic ulcer or suspected neoplasm. There were 176 such operations at this hospital from 1954 through 1960; 130 of the patients were men and 46 were women—the youngest was a 22-year-old man and the oldest was an 81-year-old woman.

Perforated Ulcers. Twenty-eight patients (26 men and 2 women) had perforations—18 in duodenal ulcers, 9 in gastric ulcers, and 1 with gastric carcinoma. Most patients presented the familiar picture of acute upper abdominal pain, a board-like abdomen, and a history of peptic ulcer. Some had had symptoms for years and had perforated, bled, or become obstructed before.

Free air visualized on films of the abdomen is highly regarded as a diagnostic sign. Of the 8 patients with gastric perforations who had x-ray studies, 5 (62%) showed free air. Of the 14 patients with duodenal perforations who had abdominal films, 8 (57%) had free air.

Twenty patients with perforation (5 gastric and 15 duodenal) were treated by simple closure; 2 died, a mortality rate of 10 per cent. Eight patients with perforation (5 gastric and 3 duodenal) were treated by immediate gastric resection and all recovered. Three of these resections were of the Billroth I type and 5 were Billroth II. No known perforations were treated without operation.

Mortality in Patients with Perforated Ulcers. A 65-year-old man died of bronchopneumonia on the twelfth day following simple closure of a gastric perforation. A 59-year-old man developed acute gastric dilatation on the ninth postoperative day, vomited, aspirated, and died.

Bleeding Ulcers. Thirty-eight patients were operated upon because of bleeding—24 men and 14 women—some as emergencies, some semi-electively or electively, for persistent or recurring hemorrhage. There were 8 gastric ulcers, 25 duodenal, 2 stomal and in 3, no exact bleeding site could be determined.

Twenty-nine of the 38 patients with bleeding ulcers were treated by Billroth II gastric resection (usually a retrocolic Hofmeister type); this group included 21 duodenal ulcer patients, 4 gastric ulcers, 2 stomal, and 2 indeterminate. Two of these 29 Billroth II procedures included a vagotomy. Eight patients had Billroth I procedures, 4 including vagotomy. The 6 vagotomies were all performed on duodenal ulcer patients.

Deaths. Four of the 38 patients with bleeding ulcers died, a mortality rate of 11 per cent. A 34-year-old man died of staphylococcal enterocolitis; a 70-year-old man, from continued bleeding from a retained duodenal ulcer after a Billroth II resection; a 51-year-old woman, from cardiac arrest on the operating table after massive hemorrhage; and a 77-year-old woman with bleeding duodenal ulcer and liver metastases from a uterine carcinoma failed to recover from anesthesia following resection.

Obstructing Ulcer. Thirty-one patients—25 men and 6 women—had pyloric obstruction, 28 from duodenal ulcer and 3 from prepyloric gastric ulcer. Most of these patients had long histories of ulcer, some with previous perforation or bleeding and all had lost weight. They had been treated by nasogastric suction decompression for varying lengths of time.

Three of these patients were treated by gastroenterostomy alone, 5 had a Billroth I resection (3 with vagotomy) and 23 had a Billroth II resection (3 with vagotomy).

Two patients died, a mortality rate of 6 per cent. A 48-year-old man died of staphylococcal pneumonia. A 46-year-old woman treated by gastroenterostomy alone early in this series died of afferent loop obstruction.

Intractable Ulcer. Forty-four patients (35 men and 9 women) were operated on because of unrelieved pain, repeated perforations, bouts of bleeding or obstruction, or combinations of these complications; there were 30 duodenal and 14 gastric ulcers in this group; 2 patients had both. Again the most common surgical procedure done was the Billroth II gastric resection, with a trend toward other procedures in recent years. There were 22

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Billroth II procedures and 19 Billroth I, 11 with vagotomy. One patient had a vagotomy and gastroenterostomy, one a vagotomy and pyloroplasty, and one a segmental resection and pyloroplasty.

Three patients died, a mortality rate of 7 per cent. A 78-year old-man died of a myocardial infarction on the fourteenth postoperative day; a 32-year-old man died of renal shutdown; and a 53-year-old man, operated upon for a gastrojejunocolic fistula 17 years after a gastroenterostomy, developed gangrene of the transverse colon following resection of the fistula.

Neoplasms. Thirty-one patients were operated on because of primary carcinoma of the stomach. One of these was diagnosed preoperatively as a benign gastric ulcer, but the surgeon recognized it as malignant at operation. Another patient with gastric carcinoma presented as a perforation. There were 3 postoperative deaths, a mortality rate of 10 per cent. One of these deaths was due to ischemic necrosis of the gastric remnant of a near-total gastrectomy.

The indications for gastric surgery and the respective mortalities are listed in Table 1.

TABLE 1—*Indications for Gastric Surgery 1954–1960*

	No. of Cases	Died	Per Cent Mort.
Perforation	28*	2	7
Bleeding	38	4	11
Obstruction	31	2	6
Intractability	44	3	7
Neoplasm	36*	3	9
	176	14	8

*The patient with perforating gastric cancer is included both in the perforations and the neoplasms.

TABLE 2—*Follow-up of 28 Patients with Perforated Ulcer*

Operation	No.	Died Post-Op.	Lost to Follow-Up	Further Treatment	Well
Simple closure	20	2	2	7	9
Immediate resection	8	0	0	0	6

Four of the patients treated by simple closure needed further surgery because of repeat perforations, or bleeding, or obstruction. All 4 had resections. Three patients have ulcer symptoms which are being controlled by medical measures. Nine remained well without further surgical or medical treatment.

One of the 8 patients treated by immediate resection was the woman with a perforating carcinoma. She died 9 months later of metastases. One man died 8 months later of pneumonia. The 6 survivors are all well.

TABLE 3—*Follow-up of 38 Patients with Bleeding Ulcers*

No.	Died Post-Op.	Lost	Traced	Results	
				Poor	Good
38	4	2	32	7	25

Two patients have had persistent iron-deficiency type anemias. One is troubled with the dumping syndrome. Four are below their preoperative weights and are able to eat only small amounts of food at one time.

TABLE 4—*Follow-up of 31 Patients with Obstructing Ulcers*

No.	Died Post-Op.	Lost	Traced	Results	
				Poor	Good
31	2	3	26	4	22

One patient has a stomal ulcer which has bled and produced pain. Three others have had intermittent bleeding and pain.

TABLE 5—*Follow-up of 44 Patients with Intractable Ulcers*

No.	Died Post-Op.	Lost	Traced	Results	
				Poor	Good
44	2	3	39	3	36

The best results were in this group. Three patients did have poor results; one has a dumping syndrome and two have been unable to maintain their preoperative weight.

TABLE 6—*Stomach Tumors*

	No.	Op. Deaths	Died Metas.	Died Other	Lost	Alive
Ca of stomach	31	3	17	3	5	3
Extrinsic Ca	3		1			2
Benign tumor	2					2
	36	3	18	3	5	7

Table 6 lists the experience with gastric neoplasms. Only 3 of the 31 patients with carcinoma are known to be alive. Seventeen died of metastases, 3 died of other diseases, and 5 were lost to follow-up.

Two of the cases of extrinsic carcinoma had transverse colon carcinomas invading the stomach. Both of these patients were alive and well years after combined colon and gastric resection.

One can only welcome such reports as Moore's,[1] of the decrease in incidence of carcinoma of the stomach.

Discussion. There was little correlation demonstrable between the type of operation done and the results. The Billroth II Hofmeister type was by far the most common operation, but there has been a recent trend toward vagotomy and hemigastrectomy. Too few vagotomies and drainage procedures were done to reach conclusions. It is my opinion that duodenal stump complications, and dumping symptoms with the gastrojejunostomies are balanced by a tendency to gastric retention with gastroduodenostomies (with or without vagotomy).

Except for carcinoma surgery, the trend today, as presented in the literature, is toward smaller resections[2]—vagotomy and hemigastrectomy or antrectomy[3,4] or vagotomy and gastroenterostomy[5] or pyloroplasty[6]—for duodenal ulcer; and wedge excision for benign gastric ulcer. Zollinger[2] suggests surgery based on the patient's weight, the stomach-sparing procedures for thin patients.

As for gastroduodenal perforation, Bowers[7] reports good results with nonoperative management—gastric suction and antibiotics in selected cases, or at most simple closure. Jordan and DeBakey[8] recommend immediate gastric resection. Barrow, Worman, and Hurley[9] found room for all three methods—suction, simple closure, and gastric resection. A fourth possibility for treating perforations is pyloroplasty and vagotomy.[10]

Wangensteen's local hypothermia[11] in upper gastrointestinal hemorrhage certainly merits thoughtful attention by all who treat patients with bleeding ulcers. Here again, vagotomy with pyloroplasty has advocates.[12]

In this series, no pancreatic tumors were noted either at operation or autopsy, but the Zollinger-Ellison[13] syndrome should be suspected in patients with peptic ulcer who do not respond to intensive medical or surgical treatment. Friesen[14] has extracted a gastrin-like substance from pancreatic islet cell carcinoma in a patient with this syndrome.

Summary. The recent status of gastric surgery at one hospital is reviewed. Bleeding ulcers present the most difficult problem, aside from carcinoma. Physicians and surgeons should become cognizant of the role of the pancreas in the etiology of peptic ulcer, the possible benefits of local gastric hypothermia in bleeding ulcer, and the role of such operations as vagotomy and antrectomy, gastroenterostomy or pyloroplasty for peptic ulcer.

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REFERENCES

1. Moore, G. E.: The decrease in incidence of cancer of stomach (editorial), Surg. Gynec. & Obst. 114:209–210 (Feb) 1962.
2. Zollinger, R. M., and Williams, R. D.: Considerations in surgical treatment for duodenal ulcer, J.A.M.A. 160:367–373 (Feb 4) 1956.
3. Scott, H. W., Jr., Herrington, J. L., Jr., Edwards, L. W., Shull, H. J. et al.: Results of vagotomy and antral resection in surgical treatment of duodenal ulcer, Gastroenter. 39:590–597 (Nov) 1960.
4. Palumbo, L. T., Sharpe, W. S., Lulu, D. J., Vespa, R., and Colon-Benet, J.: Antrectomy with vagectomy or partial gastrectomy with or without vagectomy for chronic duodenal ulcer, Ann. Surg. 151:367–373 (Mar) 1960.
5. Hoerr, S. O.: Now which operation for chronic duodenal ulcer?, Postgrad. Med. 28:219–223 (Sept) 1960.
6. Farris, J. M., and Smith, G. K.: Vagotomy and pyloroplasty, Ann. Surg. 152:416–426 (Sept) 1960.
7. Bowers, W. F., Geer, T. M., Hughes, C. W.: Perforated duodenal ulcer, A.M.A. Arch. Surg. 82:293–297 (Feb) 1961.
8. Jordan, G. L., Jr., and DeBakey, M. E.: Surgical management of acute gastroduodenal perforation, Am. J. Surg. 101:317–324 (Mar) 1961.
9. Barrow, D. W., Worman, L. W., Hurley, J. D.: Treatment of patients with acute perforation of peptic ulceration, A.M.A. Arch. Surg. 77:256–290 (Aug) 1958.
10. Pierandozzi, J. S., Hinshaw, D. B., and Stafford, C. E.: Vagotomy and pyloroplasty for acute perforated duodenal ulcer, Am. J. Surg. 100:245–250 (Aug) 1960.
11. Wangensteen, O. H., Peter, E. T., Nicoloff, D. M., Walder, A. I., Sosin, H. and Bernstein E. F.: Gastric freezing for duodenal ulcers J.A.M.A. 180: 439–444 (May 12) 1962.
12. Dorton, H. E.: Vagotomy, pyloroplasty and suture; safe and effective remedy for duodenal ulcer that bleeds, Ann. Surg. 153:378–382 (Mar) 1961.
13. Zollinger, R. M., and Craig, T. V.: Ulcerogenic tumors of pancreas, Am. J. Surg. 99:424–432 (Apr) 1960.
14. Friesen, S. R., Tracy, H. J., Gregory, R. A.: Mechanism of gastric hypersecretion in Zollinger–Ellison syndrome, Ann. Surg. 155:167–174 (Feb) 1962.

Secondary Abdominal Pregnancy

By MILTON F. GUTGLASS, M. D. and YASAR ATAMDEDE, M. D.

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■ ADVANCED extrauterine pregnancy may belong to any one of the following types, according to King:

1. *Primary ovarian pregnancy*: This is a very rare condition, but the ovary seems to be more able to accommodate itself without rupture to the growing pregnancy than the tube.

2. *Primary peritoneal (abdominal pregnancy):* This possibility is denied by most authors, but no reason is given as to why an ovum should not occasionally be fertilized by a wandering spermatozoon and become implanted at some point within the general peritoneal cavity and subsequently develop to term.

3. *Primary tubal pregnancy*: While the great majority of primary tubal pregnancies rupture at an early date, there have been a certain number of cases recorded where the tube has undergone progressive distention up to the size of a full-term pregnancy.

4. *Intraligamentous pregnancy*: In frequency, this variety is encountered next most commonly after secondary abdominal pregnancy. This condition is brought about when a tubal pregnancy ruptures between the folds of the broad ligament.

5. *Secondary abdominal pregnancy*: This is the most common form of advanced extrauterine pregnancy. This most often arises after intraperitoneal rupture or abortion of a tubal pregnancy or rupture of a primary ovarian pregnancy, or further rupture of an intraligamentary pregnancy, or slow rupture of a Cesarean scar. In this event, the ovum survives and retains sufficient placental attachment for continued development in the abdominal cavity.

The fate of the extrauterine fetus may be one of the following:

1. *Survival of the child*: In a relatively small number of cases where the condition is recognized and abdominal section is carried out, there is a fair chance of survival. In none of the cases presented here was there survival of the child.

2. *Death of the child*: Hemorrhage or inadequacy of the placental circulation resulted with the death of the child before term. More commonly, death takes place at term or afterwards, following a false labor or unsuccessful attempt at the induction of labor.

3. *Maceration*: Spalding's sign and noticeable shrinkage of the sac with absorption of the liquor amnii follows rapidly after death of the fetus.

4. *Suppuration*: The source of infection is mostly from the bowel. Eventually, the bones of the fetus usually ulcerate through the rectum, vagina, bladder, or anterior abdominal wall.

5. *Mummification and adipocere formation*: If suppuration fails to occur, the fetus becomes transformed into a greasy, greenish-yellow substance.

6. *Calcification and lithopedion formation*: Calcification may not be limited to the child alone, but may involve the placenta and the membranes.

Incidence. Eastman estimates that abdominal pregnancy occurs once in 15,000 pregnancies. Douglas and Kolin reported a ratio of abdominal pregnancy to live births was one to 16,370. Lee found one abdominal pregnancy in 9,999 pregnancies.

Clinical Stages. Five clinical stages of extrauterine pregnancy were evident as follows:

1. Symptoms of early pregnancy were noted by nearly all patients.
2. A phase of threatened or actual rupture of the ectopic pregnancy was apparent in at least half of the patients.
3. Symptoms of continuation of the pregnancy supervene in patients who are not treated at this time and who do not die of the effects of rupture.

Fig. 1—X-ray film showing abnormal fetal position.

4. A history of false labor; and, in some cases, a uterine cast may pass.

5. Late clinical manifestations are very diverse and spread over weeks, months, or even years, depending upon the time elapsing before diagnosis is made.

Diagnosis. Diagnosis depends first upon recognizing that the patient is pregnant and second on establishing the fact that pregnancy is extrauterine. Certain diagnostic aids described in the literature which proved of little value are abdominal crisis in early pregnancy, palpation of superficial fetal parts, unusually loud fetal heart tones, inability to palpate the round ligaments or Braxton Hicks contractions.

There are, however, some valuable aids to early diagnosis. The child is usually in an abnormal position, transverse, oblique, breech, and also is often unusually high in position in relation to the pelvic brim, and its attitude is frequently abnormal, there being a tendency to extension in an abdominal pregnancy and hyperflexion and compression in an intraligamentous pregnancy. A definite cervical displacement in some cases was found.

Tests for making diagnosis of abdominal pregnancy are:

1. *Culpocentesis and paracentesis:* The presence of free intraperitoneal blood confirms the diagnosis of either abdominal or tubal pregnancy. Hibbard reported using this method on 13 occasions. Five of 6 abdominal taps demonstrated blood as did 6 of 7 culpocenteses. This procedure was not performed in any of the cases presented here.

2. *Pregnancy tests* may be of some value to rule out whether the mass is due to pregnancy or not. In advanced extrauterine gestation, the test would be of little value.

3. *Pitocin test:* A gravid uterus should respond to oxytocic (Pitocin) stimulation. If there are no palpable contractions following Pitocin administration, one should strongly consider the possibility of an extrauterine pregnancy. Certainly, successive attempts at inducing labor with Pitocin without any uterine response should make the physician aware that an abdominal pregnancy may be the cause. The Pitocin test was used in 3 of 8 patients, and was the "clue" to the diagnosis. In each instance, multiple attempts using Pitocin were unsuccessful.

4. *X-ray:* This appears to present the most accurate and reliable method for preoperative diagnosis. Features suggestive of possible extrauterine pregnancies are:

(a) Abnormal presentations, especially a transverse lie with the dorsum of the fetus cephalad.

(b) Absence of uterine shadow surrounding the fetus.

(c) Signs of fetal death such as overlapping of bones of the fetal skull and hyperflexion of the spine.

(d) Occasionally calcification of the amniotic sac.

(e) Unusual clarity of fetal parts because the fetus is not surrounded by the uterine wall.

(f) Maternal intestinal gas shadows overlying and even caudad to the fetus. May even be intermingling with fetal parts.

(g) Cystography reveals only a small pressure defect on the fundus of the bladder because of the small uterus.

(h) Appearance of fetal parts posterior to the lumbar spine. A fetal part can project posteriorly to the lumbar vertebrae only if the fetus is extrauterine. This was described by Weinberg & Sherwin in 1956.

(i) Hysterography with opaque media: Demonstration of a small empty uterus, distinct from the fetus, is positive proof of an extrauterine pregnancy. In our series, this diagnostic aid was used successfully upon 3 occasions, all of which led immediately to the proper diagnosis.

Treatment. There is no doubt that the correct treatment of this condition is to carry out a laparotomy as soon as the diagnosis is made, except possibly on certain patients nearing term, when delay of a few weeks may result in a living baby.

Management of the Placenta. The most difficult and dangerous part of the operation is the management of the placenta. This depends primarily on two factors: location of the placenta, and whether the fetus is viable or has recently been so. If the placenta is located where there would be difficulty in controlling its blood supply, it is safer to leave the placenta in situ. The membranes and cord should be trimmed close to the placenta. The placenta left in situ will either be absorbed, supurate and drain or calcify and sometimes require secondary removal. In this series, three placentae were allowed to remain in situ, and in one patient marsupialization of the amniotic sac to the anterior abdominal wall was accomplished. In one patient drainage of an abdominal abscess was performed three weeks postoperatively.

The most dangerous method of placental management is total removal. This is accompanied by the highest mortality and lowest morbidity. Removal should only be attempted when the fetus has been dead long enough to be partially macerated.

The following three cases are reported in detail.

Case 1: This 27-year-old female, a hotel maid, was admitted to the hospital with the complaint of intermittent low abdominal cramps of about two months duration. She also had nausea and vomiting.

Fig. 2—A uteragram showing positive proof that the fetus is extrauterine.

Fig. 3—A uteragram showing that the fetus is extrauterine and that fetal death is present.

She was gravida 3, para 2, with her last normal menstrual period 12 weeks prior to admission.

The patient was well until about the first part of June when she began having irregular cramps and bleeding of one days duration, requiring the use of several pads. This bleeding continued intermittently. Pelvic examination revealed a firm mass in the cul-de-sac, the size of which was difficult to ascertain because of generalized abdominal tenderness. The uterus felt anterior and high. Preoperative laboratory studies showed a hemoglobin level of 9 Gm. per 100 ml. There was sugar and acetone in the urine. A chest x-ray film and a flat plate of the abdomen revealed normal findings.

Fig. 4—A cystagram showing fetus in right iliac fossa

The patient was taken to surgery on the day after admission with the preoperative diagnosis of incarcerated ovarian cyst with torsion. When the peritoneum was opened, approximately 750 to 1,000 ml. of liquid and clotted blood was found. Floating on the top of the blood was a well-formed fetus measuring approximately 10 cm. The fetus was attached by a cord to the placenta which was lying in the pelvis adherent to the posterior aspect of the cervix, posterior aspect of the right broad ligament, and rectum. A marked decidual reaction of the surrounding bowel was noted. The right tube was filled with blood and its distal two-thirds measured approximately 2 cm. in circumference. This tube was bound down posteriorly to the placental tissue and right broad ligament. A partial salpingo-oophorectomy was done. A portion of the placenta was left attached to the anterior aspect of the rectum.

On the fifth postoperative day the patient passed a decidual cast. She was discharged two days later in good condition.

Case 2: This 31-year-old colored female, gravida 1, para 0, was admitted on the medical service. Her last normal menstrual period was nine months prior to admission. She had been feeling ill for five to six months. At about six to seven months gestation, she had hypertension, edema, and rapid weight gain; she was hospitalized, and she responded well to treatment. Five days prior to admission she vomited all day and the next day she felt "feverish" and began coughing. She felt very weak and tired.

On admission her temperature was 100.6 F., blood pressure was 130/80, and pulse rate 128. Fetal heart tones had never been heard. Her hemoglobin level was 6.9 Gm. per 100 ml. and she had a leukocyte count of 21,400. A chest x-ray film revealed marked overlap of the cranial bones indicating evidence of maceration of the head and acute extension of the spine rather than flexion.

After several blood transfusions, the induction of an oxytocic, Pitocin, was attempted intravenously. During that time, the cervix barely admitted the tip of the little finger and a large fibroid was found in the posterior cul-de-sac. Rupture of the bag of waters was impossible. The intravenous administration of Pitocin did not produce any uterine contractions. Four trials of induction failed and an opinion of extrauterine pregnancy was expressed. A hysterogram revealed relatively normal filling of the uterus, which was displaced anteriorly, and it appeared that the pregnancy was ectopic.

Ten days after admission a laparotomy was performed. Upon reaching the peritoneal surface, a thick amniotic sac covered with adherent bowel was encountered. The placenta was implanted on the posterior wall of the abdominal cavity, extending down over the sacrum and into the cul-de-sac. The amniotic sac was opened and a macerated fetus approximately six to seven months size was delivered. Two large Penrose drains were inserted into the amniotic sac, and were carried upward to the abdominal wall and marsupialized. This marsupialized area formed a draining sinus. The postoperative period was quite stormy, but the patient was discharged after four weeks in good condition.

Case 3: This 27-year-old colored female, gravida 2, para 1, was admitted to the hospital with the diagnosis of term pregnancy and intrauterine death of the fetus. Her last normal menstrual period was a year before. The pregnancy had progressed fairly well, except for some irregular vaginal bleeding pe-

Fig. 5—X-ray evidence of fetal death. Note overriding of skull bones.

riods. The patient felt life until two months prior to admission which was more than a week later than the estimated date of confinement.

An x-ray film of the abdomen was taken and the patient was told that the baby was dead. Three attempts of intravenous induction of Pitocin failed. Examination revealed a term pregnancy, no fetal heart tones, head presentation, and a foul-smelling vaginal discharge.

The patient came in again for another induction of Pitocin, at which time her hemoglobin level was 9.6 Gm. per 100 ml. with a fibrinogen level of 325 mg. X-ray film of the abdomen revealed a dead fetus, apparently intrauterine in location. A carefully executed vaginal examination revealed that the cervix was found displaced to the left and high in the pelvis, and continuing from it was a triangular mass, possibly uterus. The head of the baby was bulging to the anterior wall of the vagina. During intravenous administration of Pitocin, there were rhythmic contractions of this triangular mass, but no contractions on the main mass containing the fetus.

Thirteen months after the patient's last menstrual period laparotomy was done. On opening the abdominal cavity, there was found an intraligamentous mass measuring approximately 30 cm. in diameter, and the right round ligament was coursing over the anterior aspect of the mass. The uterus was normal in size and displaced to the left of this mass. A subtotal hysterectomy and bilateral salpingo-oophorectomy was done. The pathology report was intraligamentary ectopic full-term pregnancy. The duration of the pregnancy was estimated at approximately 34 weeks gestation. The patient was discharged in good condition nine days after surgery.

Summary. Abdominal pregnancy is rare, difficult to diagnose, but should be suspected whenever there is abdominal pain, vaginal bleeding, and localized tenderness during the course of pregnancy. Treatment demands abdominal exploration if the diagnosis is made or strongly suspected. Management of the placenta must be individualized. Total removal of the placenta carries with it the highest mortality and lowest morbidity. Use of the Pitocin test and the uterogram will result in a high percentage of correct preoperative diagnoses.

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REFERENCES

1. Bansmer, G. and Layton, R. H.: Abdominal pregnancy with massive hemoperitoneum; report of case, West. J. Surg. 66:32, 1958.
2. Barber, J. F. and Rathbun, L. S.: Term abdominal pregnancy with survival of mother and child, Am. J. Obst. & Gynec. 76:822, 1958.
3. Bradford, W. Z.: Extraperitoneal pregnancy with massive retroperitoneal hemorrhage, Obst. & Gynec. 11:722, 1958.
4. Cavanagh, D.: Primary peritoneal pregnancy; rationalization or established entity? Omental transference as an alternative explanation, Am. J. Obst. & Gynec. 76:523, 1958.
5. Cerone D. M. and Cicalese, G. T.: Term abdominal pregnancy with living fetus; report of case, Obst. & Gynec. 14:368, 1959.
6. Crawford, J. D. and Ward, J. V.: Advanced abdominal pregnancy, Obst. & Gynec. 10:549, 1957.
7. Hibbard, L. T.: The management of secondary abdominal pregnancy, Am. J. Obst. & Gynec. 74:543, 1957.
8. Hunter, R. M., Hartley, A. A, Tropea, E., Jr. and Ulin, A. W.: Abdominal pregnancy followed by elimination of the placenta through the bladder; case report, Am. J. Obst. & Gynec. 76:539, 1958.
9. Jaffe, I. A.: Abdominal pregnancy with survival of mother and child, New York J. Med. 57:1956, 1957.
10. Rodriguez, C. and Siegel, I. A.: Primary peritoneal pregnancy; report of case, Obst. & Gynec. 15:394, 1960.
11. Selman, A. N.: Ectopic pregnancy (abdominal) with a living fetus that survived, Am. J. Surg. 93:1036, 1957.
12. Siegler, A. M. and others: Endocrine studies in two instances of term abdominal pregnancy, Am. J. Obst. & Gynec. 78:369, 1959.
13. Stauf, J. L., Holzaepfel, J. H. and Newkirk, E. M.: Three unusual cases of ectopic pregnancy; secondary abdominal; primary ovarian, and rupture into the broad ligament, Ohio M. J. 54:493, 1958.
14. Stromme, W. B., Reed, S. C. and Hayma, E. W.: Abdominal pregnancy; early diagnosis and delivery of a surviving infant; report of case, Obst. & Gynec. 13:109, 1959.
15. Todes, J. V.: Advanced abdominal pregnancy; its radiological diagnosis, Brit. J. Radiol. 31:28, 1958.
16. Ware, H. H., Jr.: Observations on 13 cases of late extrauterine pregnancy, Am. J. Obst. & Gynec. 55:561, 1948.
17. Weinberg, M. S., Salz, M. and Funaro, S.: Case of intra-abdominal pregnancy with follow-up tests for disappearance of placental activity, Am. J. Obst. & Gynec. 76:542, 1958.
18. Weinberg, A. and Sherwin, A. S.: New sign in roentgen diagnosis of advanced ectopic pregnancy, Obst. & Gynec. 7:99, 1956.
19. Zuspan, F. P., Quilligan, E. J. and Rosenblum, J. M.: Abdominal pregnancy, Am. J. Obst. & Gynec. 74:-259, 1957.

CASE REPORT

Primary Fibroleiomyosarcoma of Spermatic Cord

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■ BECAUSE of the rare occurrence of primary spermatic cord tumors, the literature is lacking in their description, as well as their treatment. In 1942 Schulte[1] reported a review of the literature with his own cases, and at that time there were 250 recorded cases of spermatic cord tumors. Interestingly enough, 60 to 70 per cent of the cases were benign. Strong[2] noted that the majority of the benign tumors were lipomas, fibromas, and mixed tumors; and he further mentioned that the malignant tumors without exception were carcinomas or at least tumors with sarcomatous elements.

Malignant tumors of the spermatic cord can occur in any age group, and their type can be quite variable. Shivers[3] reported on a rhabdomyosarcoma of the spermatic cord in a 16-year-old colored boy. In 1940 Graves, Kickham, and Buddington[4] recorded a case of teratoma of the spermatic cord in a 72-year-old man. Also in that year, Dreyfuss and Lubash[5] presented a malignant mixed tumor (lipo-osteo-fibrosarcoma) found in a 54-year-old man. Prince,[6] in 1942, reported a case of angio-endothelioma in a man 63 years of age; he stated that this brought the total number of recorded cases of malignant tumor to 75. In 1944 Lewis et al.[7] recorded a case of carcinoma of the spermatic cord and epididymis that was secondary to primary carcinoma in the stomach of a man 19 years of age.

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The etiology of tumors of the spermatic cord is not known. In common with tumors in general, trauma probably only serves to focus attention on a pre-existing and otherwise silent mass, and it is doubtful whether such injury is of real etiologic significance.

The patient usually presents himself with a "lump" in his inguinal area. In benign lesions, the patient usually states that a mass has been present for months or years. However, as the tumor increases in size, it produces local discomfort, dragging sensation, and may be tender. These symptoms are undoubtedly due to the weight of the tumor.

Physical examination usually shows a sharply circumscribed, firm, freely movable mass that can be readily distinguished from the epididymis and the testicle. The malignant neoplasm manifests a rapid increase in growth in shorter duration.

Malignant tumors of the spermatic cord characteristically invade the adjacent structures. In addition, metastases have been recorded in the regional, abdominal and thoracic lymph nodes, liver, lung, and kidney.

A clinical diagnosis of tumor of the spermatic cord is made relatively easily. The palpation of a normal testis and epididymis helps to localize the lesion, and the absence of transillumination aids in differentiating it from loculated fluid. In a differential diagnosis, the following should be considered: hernia, hydrocele, spermatocele, paradidymis, appendix of testis, and infections of the cord.

The accepted treatment is surgical removal. Generally, irradiation therapy is advocated as a follow-up. Strong[2] recommends orchiectomy followed by intensive radiation of para-aortic lymph nodes. In his opinion, radical dissection of the para-aortic lymph

nodes is not feasible, for metastasis of the sarcomatous tumors is as frequent by way of the blood vessels as it is by way of the lymphatic channels.

The prognosis in cases of malignancy is fair. Thompson's[8] patient with myosarcoma was alive 12 years after surgery, and another with fibrosarcoma died of a recurrent lesion. Graves'[4] patient with teratoma of the spermatic cord was well 2½ years postoperatively. The patient with angio-endothelioma of the spermatic cord, reported by Prince,[6] showed postoperatively what apparently was metastasis behind the right eye. This lesion was destroyed by irradiation and the patient was subsequently well for 8 years.

Case Report. A 49-year-old white male, who had been a truck driver for 20 years, had been "healthy all of his life." His father died of heart disease, and his mother died of a "stroke." The patient had one brother and one sister who were living and well.

On or about June 1, 1956, he experienced a "stitch" in the right inguinal area while lifting a box on his job. However, three or four days later, while examining himself, he noted a mass in the right inguinal area. This mass was nontender and hard. Because of persistence of this mass, he was seen by his family doctor who concluded that the patient had some disease of the spermatic cord or testicle. Examination on that date showed a large, hard mass which was nontender and measured approximately 10 x 6 cm. It did not transilluminate and did not increase in size with increased intra-abdominal pressure. It was independent of the testis, and general physical examination showed no other positive findings. The patient entered the hospital on June 19, 1956, for surgery.

The operative findings showed a hydrocele of the left spermatic cord, measuring approximately 8.5 x 5 cm. On the right side the spermatic cord was involved by a multinodular tumor, which extended within 4 cm. of the testicle and 2 cm. distal to the level of the internal inguinal ring. There was no apparent pathology of the testicle and epididymis. Because of the gross findings on the right side, the spermatic cord was transected at the level of the internal inguinal ring, excising the tumor, the cord, and testicle en bloc. A hydrocelectomy was done on the left side.

The gross specimen (Fig. 1) consisted of a testis with attached epididymis and a segment of spermatic cord. The spermatic cord measured 9.5 cm. and was completely involved by a nonencapsulated, multinodular tumor of whorled, yellowish-gray to grayish-white tissue measuring 7 x 3.5 x 4.5 cm. The tumor had extended distally to within 4 cm. of the testis, and proximally to within 2 cm. of the line of amputation. The tumor was characterized by interlacing groups of large spindle-shaped cells having plump elongated, oval nuclei with prominent eosinophilic nucleoli. There was an attempt at palisading by the tumor nuclei. Mitoses were fairly frequent and atypical in some areas.

Fig. 1—Gross specimen showing the tumor of the spermatic cord and testicle. (Reproduced with permission of C. V. Mosby Co., publishers of *Anderson's Pathology*, and Doctors Anderson and Pessin)

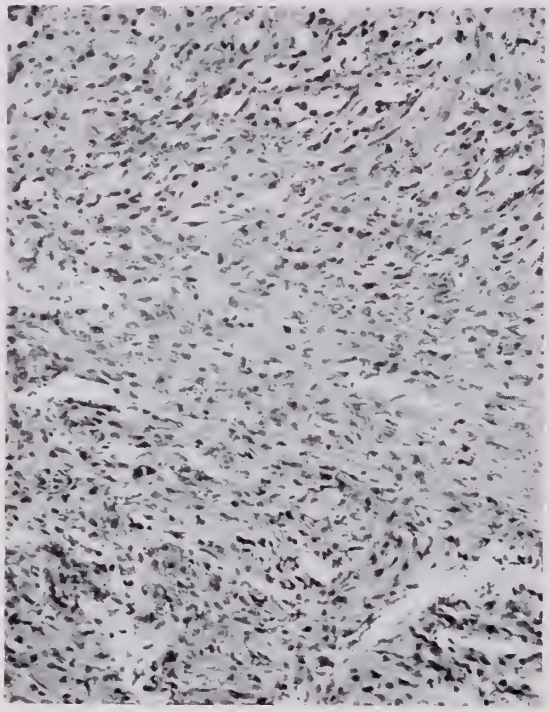

Fig. 2—Histologic section of the tumor, characterized by interlacing groups of large spindle-shaped cells.

Fig. 3—The recurrent local tumor showing the same characteristics as the original tumor.

Bizarre giant and multinucleated tumor cells were seen occasionally. Necrosis and other forms of degenerations were practically nonexistent. Throughout the tumor were irregular segments of collagenous connective tissue, probably representing remnants of host tissue. A mild chronic inflammation was seen in association with the tumor and surrounding soft tissues (Fig. 2).

The testis and epididymis were found to be free of tumor, but surrounded by approximately 50 ml. of a clear, straw-colored serous fluid.

A diagnosis of primary fibroleiomyosarcoma of low-degree malignancy of the spermatic cord was made.

Because of the nature of the tumor and the paucity of information in the literature relative to this type of spermatic cord tumor, it was deemed advisable by all concerned that the patient should be observed without being subjected to any radiation therapy or radical surgery. The patient had an uneventful postoperative course. He returned to his regular trucking job within six weeks of his surgery, and he was observed at monthly intervals. Fourteen months after his surgery, the patient showed recurrence of a right inguinal mass which was fixed at about the level of the internal inguinal ring. A resection of the local recurrence and a radical node dissection were performed.

The recurrent tumor specimen was nonencapsulated, irregular, lobulated, and solid, which measured 7 x 7.5 x 5.5 cm. The tumor was composed of homogenous, gray-white, rubbery, multinodular tissue. In several of the tumor nodules there were irregular zones of yellowish-gray central necrosis and small hemorrhages (Fig. 3). Histologically, the tumor was again characterized by interlacing, spindle-shaped cells, arranged in irregular fascicles in a haphazard manner. The individual tumor cells possessed elongated, oval, hyperchromatic and sometimes pleomorphic nuclei. The cytoplasm was fibrillar, eosinophilic, and had indistinct borders. Numerous bizarre and multinucleated giant tumor cells were frequently noted. Mitotic activity was flourishing. Although there were areas of ischemic necrosis, the tumor was generally well vascularized.

Sections of the lymph nodes showed no evidence of metastatic tumor.

Histologically, except for greater expression of cellular de-differentiation, the re-

current tumor bore a very close resemblance to the primary tumor.

Because of the recurrence of this tumor, the patient was given postoperative cobalt-60 teletherapy during the period of August 23, 1957, to September 26, 1957, in the following dosage:

Upper abdomen	10 x 15 cm.	4,000 r
Mid-abdomen	15 x 15 cm.	4,000 r
Right lower pelvis	15 x 15 cm.	4,000 r
Lumbar, upper	10 x 15 cm.	4,000 r
Lumbar, lower	15 x 15 cm.	4,000 r

This dosage resulted in a dose level of the order of 4,500 r to the para-aortic area. To exceed this figure might have resulted in untoward effect with respect to the gastrointestinal tract.

The patient was then observed every four weeks after his second operation and cobalt teletherapy. Scout films of his skeletal system showed no apparent metastasis, nor did he show any evidence of lung metastasis.

In March 1958, the patient again showed recurrence of his tumor locally in the right inguinal area. Because there was no evidence of lung or skeletal metastasis, he was taken to surgery and the localized recurrent tumor was excised. His wound healed per primum and the pathological findings were similar to those of the original tumor. This patient was clinically observed at monthly intervals with skeletal and chest scout x-ray films, every three months.

In February 1959, it was noted that the patient had a third local recurrence in the right inguinal-scrotal area. Since he showed no radiologic evidence of pulmonary or skeletal metastasis, excision of the local recurrence was done. Again, the pathological findings confirmed the recurrence of tumor (Fig. 4). Following this recurrence, the patient was given another course of 4,000 r of cobalt-60 teletherapy to the right scrotum and suprapubic area.

In December 1959, the patient experienced a persistent nonproductive cough as well as a loss of 10 pounds in weight in a six-week period. His last periodic examination had been in October 1959, at which time he showed no pulmonary or skeletal metastasis nor local recurrence. He was hospitalized in January 1960 and an x-ray film of the chest (Fig. 5) showed pulmonary metastasis. Physical examination did not reveal any local recurrence, and he was given a systemic

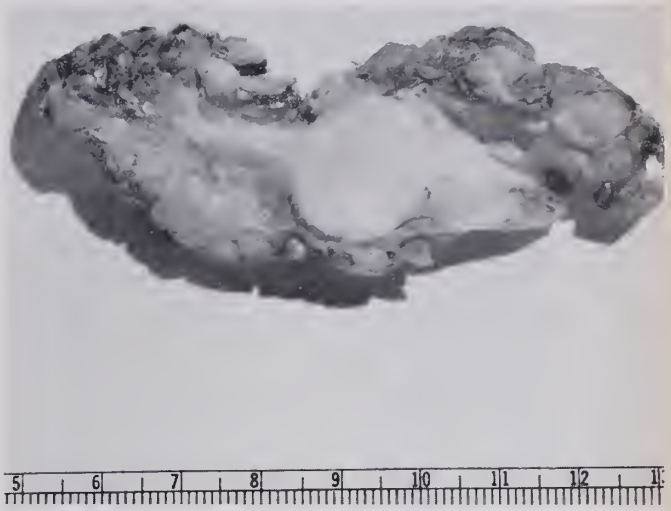

Fig. 4—Third local recurrence showing again the same characteristics as the primary tumar.

course of nitrogen mustard. He tolerated this well and was discharged symptomatically improved.

Two months later, the patient was again hospitalized for the subjective complaint of dyspnea. An x-ray film of the chest (Fig. 6) showed a pleural effusion on the left side, with an underlying mass density partially obscuring the left lower lung. Physical examination showed no local recurrence or skeletal metastasis. A thoracentesis with intracavitary instillation of nitrogen mustard was done. Cytologic examination of the chest fluid showed the presence of tumor cells. The patient was subjectively improved, and objectively he showed expansion of the lung with a minimal amount of fluid in the chest roentgenologically. One month later, the patient required hospitalization because of dyspnea and recurrence of effusion in the left side of the chest. A thoracentesis was done, and cytologic examination of the fluid failed to show any tumor cells. On these latter admissions, the patient showed no local recurrence or skeletal metastatic lesions, and repeated thoracentesis with cytologic examination showed no evidence of tumor cells. Because of the recurring pleural effusion, radiation therapy to the chest was carried out through anteroposterior and posteroanterior chest ports on the left side. However, this was of no avail. The patient had a progressive downhill course and died a respiratory death.

Fig. 5—X-ray film of the chest, January 1960, showing first evidence of pulmonary metastasis.

Fig. 6—X-ray film of the chest showing extensive pulmonary involvement with effusion.

At autopsy, almost the entire left pleural cavity, the mediastinum and one-third of the right pleural cavity were occupied by a large, nodular, lobulated, gray-white, fibrous appearing tumor measuring 26 x 20 x 19 cm. It had caused displacement of the heart to the right and the parietal pericardium had been involved by grape-like clusters of tumors, contiguous with the intrathoracic tumor. The left lung was invaded by tumor, allowing only the anterior superior segment to remain free of involvement. Five hundred ml. of blood-tinged fluid was present in the remaining left pleural space. Tumor nodules were present within the subpleural and intercostal soft tissues at the level of the left fifth and eighth ribs posteriorly. The right lung was collapsed and atelectatic. There was 200 ml. of fluid in the right pleural cavity. The tracheo-bronchial lymph nodes were involved by tumor. The peritoneal cavity contained 600 ml. of clear, serous fluid. The retroperitoneal, right inguinal and scrotal areas were free of tumor. The left testis, appendages, and scrotum were also free of tumor.

Discussion. The purpose of reporting this case is to record another primary tumor of the spermatic cord with a review of the literature. It also illustrates that although this lesion was initially adequately treated by surgery, this patient had a local recurrence within one year. At the time of his excision of this local recurrence, there was no evidence of lymph node metastasis in the tissue removed in the radical node dissection. Also, the cobalt teletherapy utilized in the local and para-aortic areas showed some effect in that there were no recurrences at the local site or at the sites of the lymphatic drainage at autopsy, although the patient had required two surgical procedures for local recurrences and an additional course of cobalt-60 therapy locally. The last local treatment was given 17 months before death. Another interesting aspect of the treatment of this case is that the systemic use of a chemotherapeutic agent such as nitrogen mustard gave the patient some transient relief, and the use of this agent locally (intracavitary) rendered the intrathoracic fluid "cell free" after application. However, it did not affect the growth of the metastatic lesion in the chest.

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ACKNOWLEDGMENT: Mr. Anthony Kuzma, FBPA, Department of Pathology, Marquette University School of Medicine, prepared the photographs.

REFERENCES

1. Schulte, T. L. et al.: Tumors of spermatic cord; report of case of neurofibroma, J.A.M.A. 112:2405–2406 (June 10) 1939.
2. Strong, G. H.: Lipomyxoma of spermatic cord; case report and review of literature, J. Urol. 48:527–532 (Nov) 1942.
3. Shivers, C. H. deT.: Rhabdomyosarcoma of spermatic cord. J. Urol. 52:266–274 (Sept) 1944.
4. Graves, R. C., Kickham, C. J. E., and Buddington, W. T.: Teratoma of spermatic cord, Amer. J. Surg. 47:116–120 (Jan) 1940.
5. Dreyfuss, M. L., and Lubash, S.: Malignant mixed tumor of spermatic cord (lipo-osteo-fibrosarcoma), J. Urol. 44:314–324 (Sept) 1940.
6. Prince, C. L.: Malignant tumors of spermatic cord; brief review with presentation of case of angioendothelioma, J. Urol. 47:793–799 (June) 1942.
7. Lewis, L. G., Goodwin, W. E., and Randall, W. S.: Carcinoma of spermatic cord and epididymis extension from primary carcinoma of stomach, J. Urol. 51:75–80 (Jan) 1944.
8. Thompson, G. J.: Tumors of spermatic cord, epididymis and testicular tunics; review of literature and report of 41 additional cases, Surg. Gynec. & Obst. 62:712–728 (Apr) 1936.

CASE REPORT

Anaphylactic Reaction to Trypsin

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■ TRYPSIN and chymotrypsin compounds have been used for many years as enzymatic treatment in a wide variety of inflammatory conditions such as phlebitis, iritis, and traumatic wounds such as contusions and ulcerations. Currently they are being actively promoted for use in bronchial asthma. Until recently, published reports made little mention of possible allergic reactions concerning these products and indeed emphasized a wide margin of safety. However, since 1960, reports have appeared documenting hypersensitivity responses and anaphylactic reaction to purified trypsin and chymotrypsin products.[1–5]

These proteolytic enzymes, extracted from animal pancreas, are not foreign proteins. However, they lend themselves to the development of hypersensitivity reactions when used repeatedly in treatment and occasionally even by casual contact when not in use for therapy. Anaphylactic reactions are rare, considering the large number of persons treated with the injectable products without incident. Yet they have occurred, even in previously nonsensitized patients,[4,5] and the critical nature of such response cannot be minimized no matter how infrequent.

Since the possibility of serious reaction from enzymatic treatment has not been generally appreciated, the following case of fatal anaphylaxis after the parenteral use of a purified trypsin is presented.

Case Report. The patient was a 36-year-old female who slipped and fell on a patch of ice resulting in a posterior fracture-dislocation of the left ankle. The fracture was splinted and the patient transported to the hospital by ambulance. Past medical history revealed no evidence suggestive of allergy other than a keloid reaction in an abdominal surgical scar. There was no previous known exposure to either trypsin or chymotrypsin medication, and the patient had had several previous surgical procedures without incident.

Physical examination revealed obesity of 250 lb., blood pressure of 144/90, and surgical scars of tongue and abdomen, in addition to the swelling and deformity of the left ankle.

A closed reduction of the fracture deformity was accomplished after the patient was anesthetized with thiopental sodium (Pentothal) and nitrous oxide. The reduction was maintained with difficulty but satisfactorily so that the extremity could be immobilized in a plaster cast.

The patient tolerated the procedure well and recovered consciousness sufficiently to converse with the attendants within five minutes of arriving in the recovery room. She was returned to her room an hour later fully conscious and oriented. A hypodermic injection of 20 mg. of a concentrated opium (Pantopon) was given at this time for pain. Ap-

proximately two hours after the procedure, the patient was given an injection of 1 ml. of aqueous trypsin compound intramuscularly. Within 5 minutes she developed severe difficulty in breathing and rapidly became both cyanotic and comatose with frothing at the mouth. In spite of prompt emergency resuscitative efforts, the patient could not be revived; she succumbed 15 minutes after onset.

An autopsy with examination of all organs, including the brain, was performed. Special staining techniques for fat showed no evidence of embolism in either the lungs or brain. The only significant finding was of marked pulmonary congestion of the lungs.

Comment. It is felt that this case represents an additional example of an anaphylactic reaction to trypsin or chymotrypsin, and its presentation is offered to emphasize the need for caution in the routine use of these products. It has been suggested that all patients should be skin-tested before such use, and that extreme caution be exercised when proteolytic enzymes are contemplated in persons who have received previous treatment with trypsin or chymotrypsin.

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REFERENCES

1. Howe, C. et al.: Hypersensitivity to purified trypsin and chymotrypsin, New England J. Med. 265:332, 1961.
2. Howell, I. L.: Anaphylactic reaction to chymotrypsin; case report, J.A.M.A. 175:322, 1961.
3. Liebowitz, D. and Ritter, H. Jr.: Anaphylactic reaction to chymotrypsin, J.A.M.A. 172:159, 1960.
4. Rose, K. D.: Anaphylactic reaction to aqueous chymotrypsin injection; development in previously nonsensitive patient, J.A.M.A. 173:796, 1960.
5. Sherline, D. M. et al.: Anaphylactic reaction to chymotrypsin; an obstetrical case report, J.A.M.A. 181: 1079, 1962.

SCHEDULE—ORTHOPEDIC FIELD CLINICS

July 1, 1963 through December 31, 1963

BUREAU FOR HANDICAPPED CHILDREN—CRIPPLED CHILDREN DIVISION

MADISON, WISCONSIN 53703

Location	*Date*	*Location*	*Date*
Ashland	August 7 and 8	Eau Claire	October 8 and 9
Wausau	August 20	La Crosse	October 16 and 17
Manitowoc	August 28 and 29	Chippewa Falls	October 23 and 24
Marinette	September 4	Racine	October 30 and 31
Kenosha	September 18 and 19	Rhinelander	November 6 and 7
Superior	September 26	Sheboygan	November 13 and 14

FOR: Clinics conducted by the Crippled Children Division of the Bureau for Handicapped Children are for persons under 21 years of age, who are referred by their family physician for orthopedic diagnosis and consultation. The reports of the examinations are then sent to the referring physician following the clinic.

REFERRAL FORMS: Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for the individual clinic so when requesting same be sure to state approximately how many forms are needed and for which clinic or clinics. It is important that we know well in advance the number of persons desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral form will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 122 West Mifflin Street, Madison, Wisconsin 53703.

CLINICOPATHOLOGIC CONFERENCE

P
C

Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: R. D. BARTHOLOMEW, M. D.

Wausau, Wisconsin

Case Presentation. The slender, balding, 39-year-old patient had enjoyed good health all his life. He was not particularly disturbed when for the first time he noted diplopia as he peered down over his right shoulder in the process of driving golf balls from the tee. (He was left handed.) A few days later he visited an optometrist who prescribed eyeglasses. The eyeglasses had no perceptible effect on his "double vision." At the optometrist's suggestion, he was examined by an ophthalmologist who told him that he had a partially paralyzed eye muscle. (Right lateral rectus muscle of the eye.) He received shots and vitamins of undetermined types and was told to wear a patch over the eye in order to give it a complete rest. This regimen was without effect on the diplopia. Two weeks after the initial episode, he was seen by a general practitioner. By this time his chief complaint had extended to include noticeable, but minimal amount of weakness in the left hand. The practitioner's thorough physical examination elicited no additional information, although careful questioning pointed out the fact that the patient had been disturbed by vague headaches and a faint ringing in the right ear of uncertain duration, but possibly more than two weeks. In the general practitioner's opinion, the patient had a "brain tumor." The doctor referred him to a neurologist. The neurologist confirmed the previous physical findings and concluded that the patient might have multiple sclerosis. In order to confirm this unusual diagnosis, the patient was referred by the neurologist to a large diagnostic clinic for a neurologic examination and consultation.

He was seen at the clinic five weeks after the onset of the diplopia. The neurologist's examination revealed: (a) complete paralysis of the right lateral rectus muscle of the eye, (b) minimal but detectable paralysis of the right orbicularis occuli muscle, (c) slight muscular weakness of the left upper and left lower extremities, (d) increased reflexes on the left, (e) a definite "extensor" response in the left foot, and (f) moderate diminution of alternating motion rate on the left.

The consultant made a point of stating that both eye grounds were normal and that the corneal sensations were intact. His conclusion was that the patient was suffering from a demyelinating disease, but noted that a brain tumor could not be effectively ruled out. The general physical examination was done by a medical resident and confirmed, but did not expand the findings of the previous examiners.

On examination his blood pressure was 140/94, and pulse 80. His pupils were bilaterally equal in size and reacted normally to light and accommodation. He was unable to move the right eye laterally. The left eye revealed no motor impairment. There was no nystagmus, strabismus, or corneal anesthesia. Facial muscles, ears, nose, throat, and neck were unremarkable. The chest was bilaterally clear to percussion. The breath sounds were essentially normal. The heart rate, rhythm, and sounds were all within normal limits. There were no murmurs. The abdomen was scaphoid, muscular, and no masses or areas of tenderness were encountered. The abdominal reflexes were present.

There was no limitation of motion of the arms or legs and no apparent muscular atrophy. There was a slight but detectable weakness of both the left arm and the left leg with no particular selection of extensor or flexor muscle groups. On neurologic examination the only positive findings were weakness of the right lateral gaze and mild weakness of both left arm and leg, associated with a positive Babinski's sign. There was no apparent abnormality of gait or posture, except possibly for some abduction and minimal flexion of the left arm when the patient sat quietly. There were no abnormal changes when pain, temperature, position,

vibration, touch, finger writing and two-point discrimination were tested. There was no astereognosis or dysarthria.

No abnormalities of blood vessels or optic disks were noted on fundoscopic examination.

Laboratory examinations at the hospitals where this patient was seen over a period of some eight weeks are summarized as follows: All of the routine blood work, including a complete blood cell count, hemoglobin and hematocrit reading, were within normal limits, as was the urinalysis. The fasting blood sugar varied between 95 and 102, and the nonprotein nitrogen between 28 and 35 mg. per 100 ml. The white blood cell count varied between 8,000 and 12,000 per cu. mm. with an essentially normal differential count. At no time was there an abnormal dominance of any particular type of cell. All of the cells seen were mature and unremarkable.

Several lumbar punctures were done. The opening pressure was 190 mm. of water, the closing pressure was 40 mm. of water. At the close of the procedure jugular compression raised the pressure to 80 mm. of water. Twenty ml. of clear spinal fluid were removed. Examination of the spinal fluid revealed the following: protein 35, sugar 74, and chlorides 120 mg. per 100 ml.; three lymphocytic cells were seen; the test for syphilis was nonreactive; gold curve was 000.000.000.0; and color was clear. (No xanthochromia was noted.)

X-ray films revealed: (a) "normal cardiac and lung field shadows with no evidence of disease," (b) "radiologically normal skull," (c) "cyst on floor of left antrum, occupying about one-third of the antrum; other nasal sinuses clear; no other abnormality noted," and (d) pneumoencephalogram: "roentgenograms showed a moderate dilatation of the left lateral ventricle without evidence of shift, no space consuming lesion could be detected."

The electroencephalograms showed a moderate abnormality in the right frontal area, the significance of which was not indicated on the patient's chart; i.e., no diagnosis could be made from it.

As the patient's disease progressed, accentuation of some of the signs and symptoms were helpful in establishing a probable diagnosis. The diagnosis was established by the pathologist at autopsy. The autopsy also indicated the reason for the patient's unexpectedly quick death some six months after the initial onset of symptoms.

Clinical Discussion. *Dr. J. L. Struthers:* Nothing is so frustrating as having a problem without an answer and especially one which appears to start as abruptly as in this particular case. There are some problems which defy accurate analysis clinically, and unfortunately, especially in my case, neurologic problems of this nature seem to fall into this group. It made me feel much better after reading the protocol to find that several neurologists and clinics here in the midwest were unable to pinpoint the diagnosis after their initial review of the case.

There seems no doubt, at least in retrospect, that this particular illness was caused by an expanding lesion. I shall attempt a brief analysis to substantiate this conclusion. Diplopia which is noted at an age incompatible with the usual causes of strabismus is to me a very serious problem and merits painstaking study. It disturbed me to find that on the initial examination by an ophthalmologist that the more serious problems were not given immediate consideration. As far as I am concerned, the lateral rectus muscle did not suddenly and without cause become weakened in a man, apparently in good health. An isolated weakness of the ocular musculature as an initial finding is not common. With a history of faint ringing in the right ear, possibly slight headache, and sixth nerve involvement, there seems to be little doubt that a localized problem is present. Add to these findings the left arm weakness, which occurred soon after the initial diplopia, and I feel that there is enough information available to put us on the right track. It is interesting that the first medical man who gave the patient a thorough physical examination was able to make a flat statement as to what he considered the probable diagnosis. With the findings of the general practitioner, I believe the consulting neurologists performed a disservice in suggesting multiple sclerosis. The reason for this is that it appeared to have all of the criteria for a localized enlarging lesion. I feel that a diagnosis of multiple sclerosis should have at least some suggestion of disconnected neurologic signs. The very clinical backbone of the disease is the bizarre nature of the findings. Diplopia plus the progressive neurologic changes all appear to point to the cerebellopontine angle of the brain.

The type of lesion that would cause this progression is the problem. There are no findings to substantiate the lesion as being due to a congenital disorder or due to an infectious origin such as, for example, tuberculosis. A subdural hematoma should not give this picture, because the higher centers of the brain should at least in some way be involved. I don't believe there are any syndromes in which aneurysm could cause the type of symptoms seen in this patient. I do not wish to over simplify the problem, but it appears to me that neither is this essentially a demyelinizing disease, since the symptoms and signs are localized in a small area of the brain. Everything about this case indicates one enlarging lesion which to me has to be a tumor. I should like to mention that two years ago a 17-year-old youth presented to me a pattern of disease very similar to this man, although somewhat more advanced in his course. It turned out that he had a large meningioma which could not be successfully removed. This 39-year-old man's course was quite rapid, and I believe that his tumor was not only enlarging, but extending so that a variety of structures, all relatively close together in the area of the pons, became involved.

I purposely ignored the laboratory and x-ray reports because as is often the case, these facilities failed to supply the answer. When the laboratory and x-ray reports are not positive, the studies might as well be disregarded. They only confirm clinical opinion in this particular case. They add nothing new to what is already suspected. I feel that angiograms might have aided where other studies failed. I do not consider this patient's sudden demise as unusual, since extension into a vital area by the neoplasm could have caused it. A sudden hemorrhage enlarging the neoplasm, or even a thrombosis could have precipitated the terminal event.

The optometrist who saw this man should be commended for his referral. This situation does not happen often enough, and I feel that we should encourage this sort of activity. It is obvious that there is no substitute for a good history, and I should certainly condemn the use of vitamins and "shots" for complaints which they could not possibly effect, though admittedly they "do something" and at least make the patient feel that he is getting some action from the person seeing him.

In my opinion the important symptoms in this particular case are diplopia, weakness of the left hand, and the ringing in the right ear. Also, I feel that the significant physical findings should include the paralysis of the right lateral rectus muscle and right orbicularis oculi muscle. It seems important to me that there was weakness of both the left arm and leg and that there were increased deep tendon reflexes on the left and a positive Babinski sign on the left. The finding of moderate diminutions of alternating motion rate on the left is suggestive of deep pathology, but does not confirm the finding of the paralysis on the left side and I should like to consider it a sign of pyramidal tract involvement rather than a cerebellar sign.

The left arm and leg weakness, the increase of dependent reflexes on the left, and the positive Babinski sign on the left, can be explained by putting the lesion in the inferior portion of the pons on the right. In this location it is transversed by the pyramidal tract fibers. It is above the point of decussation of the pyramidal tracts since the decussation occurs in the medulla. The involvement of the abducent nerve could occur in one of two places. This would be either at the nucleus, just beneath the fourth ventricle, or at the inferior portion of the pons in close proximity to the pyramidal fibers. The paralysis of the right orbicularis oculi could be easily explained by the extension of the lesion so as to involve the motor nucleus of the facial nerve as its fibers pass through the lateral portion of the pons. These assumptions would put the lesion in the area of brachium pontus and one would expect cerebellar signs (if they occurred) to be on the right side. The ringing in the ear could be explained by involvement of the eighth nerve which would be in the general area that has been discussed.

What could be the basic cause of these multiple neurologic signs and symptoms? These possibilities occur: (a) brain tumor, (b) posterior, inferior cerebellar artery thrombosis, and (c) multiple sclerosis. The only physical sign that could occur to place the lesion on the right side of the brain (poor alternation) is probably of no significance and it is felt that this poor alternation is due to pyramidal tract involvement. A posterior inferior cerebellar artery throm-

bosis still could not definitely be ruled out, but it should be noted that the involvement by thrombosis in this artery is usually more caudal with the primary signs and symptoms reflecting involvement of the upper portion of the medulla rather than the pons. It is not felt that this particular case qualifies as a typical Wallenberg's syndrome. The single diagnosis that seems to best explain all of the signs and symptoms as observed in this case could be a brain tumor involving the right side of the pons, and if one must make a guess, the best statistical gamble would be an astrocytoma possibly a Grade 3 or better, because of the rapid progression of symptoms.

Pathological Discussion. *Dr. R. D. Bartholomew:* The diagnosis appeared to be so easy for you gentlemen, that I wonder why I thought this case would be a challenge. Possibly it is because the diagnosis could not be completely established by the extensive examinations done at several clinics by very competent men. I have talked to them personally and/or have corresponded with the doctors who directed the patient's original diagnostic "work ups." All of the men felt that this patient might have a neoplasm. All were motivated by the feeling that they did not want to be the one to "close the door on hope." Because of this they pointed out that it was possible that a demyelinizing disease could cause these symptoms and signs, and that as a matter of record, there were no physical or laboratory evidences of unequivocal neoplastic disease.

I wonder if any of the discussants would have bluntly told the patient (or his close relatives) that he had a neoplasm and that no other diagnosis was feasible. Were I this patient's doctor, I would have said that while I feel there is a good possibility of a neoplasm causing the symptoms, I should like to have my findings confirmed by a colleague. Applying the general type of reasoning to malignancy in the other parts of the body, I do not know of any physician that would say, "Madam, (or Sir) the symptoms and physical signs you have demonstrated to me indicate that you have cancer and nothing else." On the contrary, the doctor would indicate that a serious matter was at hand and that he would like a surgical consultation and biopsy to establish a diagnosis. Initially in this case it was felt that there were insufficient positive signs and physical findings to warrant an exploratory operation of the cerebellopontine area of the brain. Eventually an operation was done, of course, but even then excessive bleeding forced the surgeon to stop prior to acquiring a tissue biopsy from what he considered the tumor area.

The patient succumbed as a direct result of a large, Grade 2 astrocytoma of the pons that had extended across the midline to the left and posteriorly into the right cerebellum. The terminal event was initiated by locally massive hemorrhage.

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3133 Ninth Street.

ABUSE OF ONE PINT TRANSFUSIONS

MITTY, WILLIAM F., JR.; Saint Vincent's Hospital of the Borough of Richmond, Staten Island, New York. *New York State Journal of Medicine* 62:3426 (Nov. 1) 1962.

The author reports on 272 patients who received transfusions consisting of one pint of blood. This series does not include patients with blood dyscrasias who were given one unit of blood for treatment. One hundred and forty-one of the 272 patients had hemoglobin levels of 12 Gm. or more, and 218 of the 272 had hemoglobin levels of 10 Gm. or more. Forty-nine of the 272 did not have surgery.

The author feels that many of these patients could have been managed without the use of blood transfusions. All specialties have been guilty of overusing the one pint transfusion, but surgery and obstetrics and gynecology departments have been the biggest offenders. The author feels that many surgeons and anesthesiologists give blood transfusions during an operative procedure before estimating the blood loss.

The author has outlined the average blood loss in various operative procedures. This varies from 350 cc. for an exploratory laparotomy to 2,000 cc. for an abdominal-perineal resection.

Complications of blood transfusion are: (1) hemolytic reactions, 5 per 1,000 transfusions, (2) allergic reactions, 1 to 3 per 100 transfusions, and (3) complications incident to the methods of transfusion, including air embolism, circulatory overload, cardiac arrest, and thrombophlebitis. Late complications include transmission of influenza, syphilis, hepatitis, malaria, brucellosis, and isosensitization. In 1959, 16,500 patients died from complications of blood transfusions. This is higher than the mortality from rectal carcinoma, appendicitis, diverticulitis, duodenal ulcer, cholecystitis, and intestinal obstruction.

"It is the hope of the author that this report will cause other surgeons and anesthesiologists to pause and think of the inherent dangers that we condone in allowing unnecessary one pint transfusions to be given, especially in the operating room."

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

Pharmacology of Methyldopa

an Antihypertensive Drug

By BERT K. B. LUM, Ph.D., M.D.
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■ METHYLDOPA, an aromatic amino acid, has recently been introduced as an antihypertensive agent. Chemically, the compound is α-methyl-3,4-dihydroxyphenylalanine. Only the levo form is active clinically and this form of the drug is marketed under the trade name of Aldomet.

Methyldopa has been shown to inhibit in vitro[1] and in vivo[2,3] the enzymatic decarboxylation of a number of aromatic amino acids including the precursors of norepinephrine and serotonin. The important function of the former as the principal chemical mediator in the transmission of sympathetic nerve impulses is well known. The precise physiological role of serotonin has yet to be established, although a number of physiological functions have been ascribed to this agent including that of a humoral agent in the central nervous system. In the biosynthesis of norepinephrine (Fig. 1), an early step involves the decarboxylation of 3,4-dihydroxyphenylalanine (DOPA) to form dopamine, the immediate precursor for the formation of norepinephrine. The enzyme responsible for the decarboxylation appears to be identical with the enzyme which decarboxylates a number of aromatic L-amino acids including 5-hydroxytryptophane, the immediate precursor of serotonin (Fig. 1). The enzyme has thus more recently been named aromatic L-amino acid decarboxylase.[4]

As might be predicted of a drug which inhibits aromatic amino acid decarboxylase, methyldopa has been shown to diminish tissue concentrations of norepinephrine and serotonin.[2,3,5,6] Following the administration of single doses to animals, the effect of methyldopa on serotonin tissue levels is relatively brief (less than 24 hours) so that depletion and recovery of endogenous serotonin levels appear to be related to inhibition and recovery of decarboxylase activity. On the other hand, depletion of tissue norepinephrine levels may persist for several days beyond full recovery of decarboxylase activity and may even persist after recovery of dopamine levels in tissue. Recent studies suggest that the long lasting depletion of norepinephrine is dependent upon the biotransformation of methyldopa. While capable of inhibiting decarboxylase, the drug is also a substrate for the enzyme and is thus decarboxylated to form α-methyldopamine (Fig. 2).[3,5,7,8] This amine is capable of producing a persistent depletion of norepinephrine levels in peripheral tissue.[3] Studies on α-methyl-meta-tyrosine, a decarboxylase inhibitor

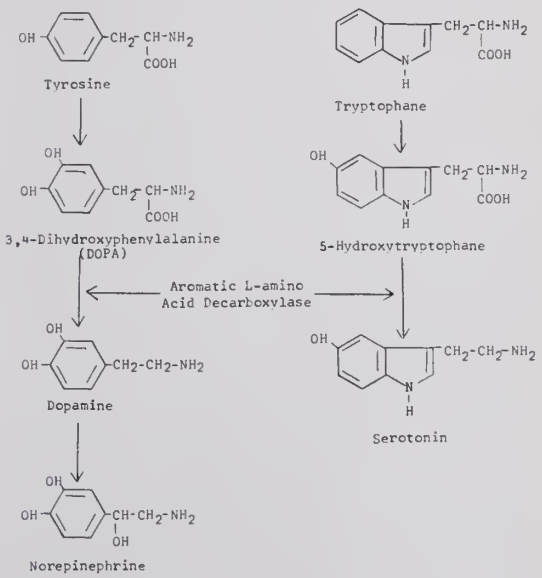

Figure 1

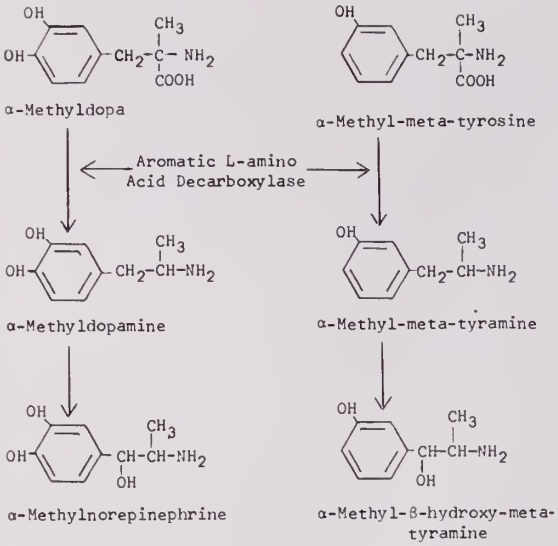

Figure 2

chemically related to methyldopa, have led to a similar conclusion; i.e., norepinephrine depletion by this agent is due to the metabolites of this compound: α-methyl-metatyramine and α-methyl-beta-hydroxy-metatyramine (Fig. 2).[9,10] These metabolites may deplete norepinephrine by impairing the process for storage of the amine.[9,10]

Despite the findings cited above, the mechanism of the antihypertensive action of methyldopa is far from clear. Decarboxylase inhibition probably does not constitute a major mechanism of action since a number of other potent decarboxylase inhibitors do not exhibit an antihypertensive action.[8] Although it seems logical to relate the hypotensive action of methyldopa to norepinephrine depletion and hence impairment of sympathetic nervous system activity, animal studies have failed to establish this as the mechanism of action. Thus, methyldopa does not inhibit the effects of cardiac sympathetic nerve stimulation[11] and does not inhibit reflex pressor responses to common carotid occlusion or central vagal stimulation.[6]

Numerous clinical reports have established methyldopa to be an effective antihypertensive drug. It has been employed successfully in moderate to severe essential hypertension. There is, however, some disagreement among the early reports as to the efficacy of this agent in very severe and malignant hypertension.[12,13] The early reports indicate that methyldopa has several advantages over other antihypertensive agents. It lowers the blood pressure in the recumbent as well as the upright position in many patients. The drug can be given orally as well as intravenously and dosage is usually easily regulated and less critical than with many other drugs. These reports also suggest that methyldopa is well tolerated by most patients and is associated with fewer untoward effects than is observed with other potent hypotensive drugs.

However, serious undesirable and toxic effects have occasionally been encountered. Mental depression and drug fever have necessitated withdrawal of the drug in some patients. In one case, the febrile reaction was associated with reversible abnormalities in liver function tests.[8] One case of agranulocytosis which reverted to normal on withdrawal of the drug has been reported.[15] Edema may occur with the use of methyldopa but this can usually be overcome by the simultaneous administration of diuretic agents. Drowsiness is a frequent side effect which may be due to depletion of serotonin in the brain.[14] This usually disappears after several days despite continued use of the drug. Symptoms of postural hypotension occur less frequently than with other potent drugs such as the ganglionic blocking agents and guanethidine. Other side effects which have been encountered include dry mouth, nasal congestion, impotence, and gastrointestinal distress. Tolerance may occur with the use of methyldopa, but it usually does not constitute a major problem. Other hypotensive agents, particularly the thiazide diuretics, potentiate the antihypertensive action of methyldopa.

REFERENCES

1. Sourkes, T. L.: Inhibition of dihydroxyphenylalanine decarboxylase by derivatives of phenylalanine, Arch. Biochem. 51: 444–456 (Aug) 1954.
2. Hess, S. M., Connamacher, R. H., Ozaki, M., and Udenfriend, S.: Effects of α-methyl-DOPA and α-methyl-meta-tyrosine on metabolism of norepinephrine and serotonin *in vivo*, J. Pharmacol. 134: 129 (Nov) 1961.
3. Porter, C. C., Totaro, J. A., and Leiby, C. M.: Some biochemical effects of α-methyl-3,4-dihydroxyphenylalanine and related compounds in mice, J. Pharmacol. 134: 139–145 (Nov) 1961.
4. Udenfriend, S., Lovenberg, W. M., and Weisbach, H.: L-amino acid decarboxylase activity in mammalian tissues and its inhibition by α-methyl DOPA, Fed. Proc. 19: 7 (Mar) 1960.
5. Carlsson, A., and Lindquist, M.: In-vivo decarboxylation of α-methyl DOPA and α-methyl metatyrosine, Acta Physiol. Scandinav. 54: 87–94 (Jan) 1962.
6. Stone, C. A., Ross, C. A., Wenger, H. C., Ludden, C. T., Blessing, J. A., Totaro, J. A., and Porter, C. C.: Effect of α-methyl-3,4-dihydroxyphenyl-

alanine (methyldopa), reserpine and related agents on some vascular responses in the dog. J. Pharmacol. 136: 80–88 (Apr) 1962.
7. Porter, C. C., and Titus, D. C.: Distribution and metabolism of methyldopa in the rat, J. Pharmacol. 139: 77–87 (Jan) 1963.
8. Gillespie, L., Jr., Oates, J. A., Crout, J. R., and Sjoerdsma, A.: Clinical and chemical studies with α-methyl-dopa in patients with hypertension, Circulation 25: 281–291 (Feb) 1962.
9. Udenfriend, S., and Zaltman–Nirenberg, P.: On mechanism of norepinephrine release produced by α-methyl-meta-tyrosine, J. Pharmacol. 138: 194–199 (Nov) 1962.
10. Gessa, G. L., Costa, E., Kuntzman, R., and Brodie, B. B.: On mechanism of norepinephrine release by α-methyl-metatyrosine, Life Sciences No. 8: 353–360 (Aug) 1962.
11. Goldberg, L. I., Da Costa, F. M., and Ozaki, M.: Actions of the decarboxylase inhibitor, α-methyl-3,4-dihydroxyphenylalanine in the dog, Nature 188: 502–504 (Nov 5) 1960.
12. Dollery, C. T., and Harington, M.: Methyldopa in hypertension: clinical and pharmacological studies, Lancet 1: 759–763 (Apr 14) 1962.
13. Cannon, P. J., Whitlock, R. T., Morris, R. C., Angers, M., and Laragh, J. H.: Effect of alpha-methyl DOPA in severe and malignant hypertension, J.A.M.A. 179: 673–681 (Mar 3) 1962.
14. Sjoerdsma, A.: Newer biochemical approaches to treatment of hypertension, Ann. N. Y. Acad. Sci. 88: 933–938 (Oct 11) 1960.
15. Hallwright, G. P.: Agranulocytosis caused by methyl dopa (Aldomet), New Zealand Med. J. 60: 567–570 (Dec) 1961.

PLASMA PROTEINS AND THE GASTROINTESTINAL TRACT

JEFFRIES, GRAHAM H., HOLMAN, HALSTED, R. and SLEISENGER, MARVIN H., New York Hospital-Cornell Medical Center, New York, N. Y.; and Stanford University School of Medicine, Palo Alto, Calif., *New England Journal of Medicine*, 266:652 (Mar. 29) 1962.

Leakage of plasma proteins into the gastrointestinal tract is a major cause of hypoproteinemia in many diseases, and may even play an important role in the normal degradation of plasma proteins.

Although all classes of plasma protein leak into the gastrointestinal lumen, only albumin has been studied. There is difficulty in measuring the globulins quantitatively due to their heterogeneity. The technics for measuring quantitatively plasma albumin degradation and leakage are discussed.

In patients with protein-losing enteropathy, balance studies following intravenous infusions of albumin demonstrate that the amino acids of albumin are partly catabolized and partly reutilized in protein synthesis. Studies using I^{131}-labeled albumin in these patients demonstrate that the plasma albumin concentration and the total albumin pool may be normal or reduced depending on the ability of the liver to maintain production of albumin.

The measurement of I^{131}-labeled albumin leaking into the gastrointestinal lumen is complicated by the excretion of free I^{131} into saliva and gastric juice and reabsorption into the intestine. Various modifications of this technic may minimize this inaccuracy. The insignificant reabsorption and the relative stability of I^{131}-labeled polyvinylpyrrolidone (I^{131}-P.V.P.) made this substance more ideal for the study of this group of patients who were shown to excrete a greater quantity of I^{131}-P.V.P. after intravenous injection than normal subjects. However, the distribution and catabolism of I^{131}-P.V.P. and albumin differ significantly. Since there is no gastrointestinal secretion or absorption of nonprotein-bound $Cr^{51}Cl_3$, the disadvantages of the I^{131}-labeled albumin are avoided. However, the Cr^{51}-labeled albumin is degraded more rapidly than I^{131}-labeled or unlabeled albumin, so this substance is not absolutely ideal for these studies.

It has been estimated that approximately one third of all degraded ablumin in a given time passes into the stomach and duodenum, which obviously represents a significant proportion of albumin catabolism. Consideration of the function of this protein loss has so far been only speculative.

The major clinical features of protein loss are generalized or dependent edema secondary to hypoalbuminemia. However, with gastrointestinal protein loss the serum cholesterol is low in contrast to the nephrotic syndrome.

A number of diseases complicated by excessive gastrointestinal plasma protein loss are described together with case records for illustration.

Excessive plasma protein leakage may occur from the acutely inflamed or ulcerated gastric mucosa. This loss of protein has also been demonstrated in patients with adenocarcinoma, diffuse mucosal ulceration, and giant hypertrophic gastritis (Menetrier's disease). Therapy of these gastric lesions may be dictated by factors other than the protein loss, e.g., neoplasm or bleeding. Gastrointestinal protein loss has been well documented in patients with chronic inflammatory disease of the small and large intestine, particularly regional enteritis and ulcerative colitis. Similar hypoproteinemia and abnormal gastrointestinal loss of protein occur as an important secondary manifestation of neoplastic involvement of the mesentery of the small intestine, particularly by lymphomatous disease. Nontropical and tropical sprue are accompanied by excessive protein loss into the gut, the effect of which is accentuated by impaired absorption of amino acids. Idiopathic protein-losing enteropathy appears to be a disease closely resembling nontropical sprue, but which does not satisfy all the criteria of the latter disease and which does not respond to a gluten free diet. Occasionally, patients with primary disease of the gastrointestinal tract may have an excessive enteric loss of plasma protein.

Several mechanisms are suggested to explain the plasma protein leakage through the gastrointestinal mucosa. There may be passive diffusion between the mucosal cells or more rarely active secretion by the mucosal cells. In some diseases the plasma proteins may be lost as constituents of inflammatory exudate from the mucosa. Finally the plasma protein loss may be secondary to disordered mucosal-cell metabolism.

THE PRESIDENT'S PAGE . . .

The Trio Became a Quartet

■ FOR AGES the sick received, usually at home, medical care administered by the original trio—the medicine man, the herbs specialist, and the volunteer female neighbor. This trio, soundly and competently, matured into the physician, the pharmacist, and the nurse of modern times.

Institutional care, mainly for isolation (the pest-house) and custodial management, evolved into the modern, efficiently organized hospital giving high quality medical care.

The trio became a quartet because the home locus for medical care had shifted to hospitals. Experience has demonstrated that medical care is at its best when the quartet works in harmony.

High standards of medical care have stimulated the development of efficient hospital governing boards, trained hospital administrators, and effective functionally organized professional medical staffs.

A study of the official constitution of each association shows a striking similarity of the aims, goals, and purposes of the four associations, each one a constituent of its own national society. Each is dedicated to constantly improving health care of our citizens and to giving constant attention to health care education.

The Wisconsin Nurses Association is "dedicated to work for high standards of nursing practice, to promote the professional and educational advancement of and the welfare of nurses to the end that all people may have better nursing care . . . to promote sound nursing practice acts and to speak for the nurses regarding legislative action for general health and welfare programs."

The Wisconsin Pharmaceutical Association's objectives include: "Its aim shall be to unite the pharmacists . . . with the intent of providing the highest possible professional service to the public, and of advancing the interests of the profession. Its duties shall be to stimulate education, foster research, and encourage scientific advancement."

The Wisconsin Hospital Association's objectives and purposes are "to promote the welfare of the people of the state through the development of hospitals and dispensaries of the state in service rendered to patients, in the encouragement of professional education and scientific research,

continued on page 357

TEACHING PROGRAMS SCHEDULED OR PLANNED

Several teaching programs have been scheduled and others are in the planning stage, under sponsorship of the State Medical Society through the CES Foundation and with support from other interested groups, several with the University of Wisconsin.

The schedule thus far includes:

Oct. 9: University of Wisconsin Pediatric Program, President's Room, State Medical Society Headquarters, Madison, 12 noon to 4 p.m.

Nov. 7: "Wilson Cunningham Day" at Platteville. This is a special teaching program in memory of Dr. Wilson Cunningham. In addition to the afternoon session there will be an evening meeting open to the public. This is being presented under a memorial grant to the CES Foundation.

Nov. 14: University of Wisconsin Neurology Program, President's Room, State Medical Society Headquarters, Madison, 12 noon to 4 p.m.

Dec. 3: "Acute Eye" Circuit, at Dodgeville (tentative).

Dec. 4: "Acute Eye" Circuit at Wisconsin Rapids (tentative).

Dec. 5: "Acute Eye" Circuit at Merrill or Antigo (tentative).

Jan. 29: University of Wisconsin Cardiology Program, President's Room, SMS Headquarters, Madison, 12 noon to 4 p.m.

Feb. 20: University of Wisconsin Orthopedic Program, President's Room, SMS Headquarters, Madison, 12 noon to 4 p.m.

Mar. 19: University of Wisconsin Endocrinology Program, President's Room, 12 noon to 4 p.m.

There are tentative plans for a series of meetings (possibly in Sheboygan, Wausau, and Fond du Lac) on "The Mildly Retarded Child." This series will probably be scheduled in early February or early March following the Wisconsin Work Week of Health Feb. 24–29.

PRESIDENT'S PAGE *continued from page 356*

the health of the public, liaison and cooperation with other organizations having similar objectives, and to do all things which may best promote hospital and outpatient efficiency."

The State Medical Society of Wisconsin's purpose is "to federate and bring into one compact organization the entire medical professional of the state . . . unite with similar societies . . . to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life."

W. J. Egan M.D.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

AUGUST 1963
Vol. 62 No. 8

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

The National Anguish

■ THE RACIAL demonstrations of 1963 may, in time, be recognized as events of great importance to the perfection of American democracy. The progress toward human equality before the law proclaimed by the Constitution of the United States and its amendments, and pragmatically confirmed by the Emancipation Proclamation, is measured now by the demonstrations. Our country is being asked by a group of its citizens whether it is indeed "The Great Western Democracy" or whether it is only masquerading to the world as an exponent of human rights. The mettle of our social structure stands tested in a way that may determine the ultimate destiny of our nation and the principles on which it was founded.

These are stirring times in which we live. The demonstrations for racial equality expose such critical issues in our democracy that we stand as much at a crossroad of destiny as Americans did in the summer of 1861. Because the Negro community of Wisconsin is relatively small and concentrated in the industrial counties, the issue of racial equality may seem remote to many of our citizens. But the issue is not industrial or metropolitan or Southern. It is a national issue. It is a human issue. Above all, it is a moral issue, and that is why it is an important issue to discuss in the editorial pages of a medical journal. For we are human beings as well as doctors.

Racial inequality has cost America dearly. The thousands of lives lost in the Civil War to establish, among other things, that slavery was not part of American culture must ever remind us that no man bears a heritage of servitude because of an accident of birth. In the century since the legal end of slavery in this country we have taxed ourselves heavily by depriving ourselves of the human resources that might have been available to us if all of our citizens had, in fact, equal opportunity. We have imposed a burden of bigotry on our national character that has made our posture in the family of nations hypocritical.

If they succeed in no other respect, the demonstrations will have forcefully shown that the problems of the Negro minority are national problems. They will have shown that discrimination because of race is wrong—economically, socially and morally. It is to be hoped that the demonstrations proceed peacefully, without the hoodlumism and impatience

that could alienate the public opinion so necessary to the Negro cause. But no matter how the events of this summer transpire, nobody—no bigot, no politician, no backwater demagogue—will ever again be able to use the tired wheezes of "state rights" or "inalienable right of the majority to oppress a minority" as excuses to support a stance of racial superiority. Respectability and morality go hand in hand, and respectable America can no longer afford the immorality of racial discrimination.

As doctors, and respectable members of our community, we will take the lead in sympathizing the goals of the peaceful, responsible demonstrators, and we will use our position to explain their methods and their purposes.—D. N. G.

GUEST EDITORIAL

Calling All Counties

EDITOR'S NOTE: If all medical societies emulated the Rock County approach for informing the public about tax supported medicine there would be far less concern about possible intrusion by government into the practice of medicine. The trick is to disseminate all of the facts accurately, clearly and concisely so that reasonable judgments can be formed, for there is abundant evidence that truly enlightened people generally side with organized medicine in rejecting the social security mechanism or any other tax scheme to provide health care.

"Operation Hometown" is a modus operandi for achieving this goal and it is difficult to think of a better method. The Rock County Medical Society deserves highest commendation for its assiduity and generosity. But ultimate success depends on like endeavor in every county medical society and there is no time to lose. Dr. Milton D. Davis of Milton, Wisconsin furnished the report that follows.

—D. N. G.

THIS SUMMER Rock County has broken all records in regard to 90 plus degree days, and this might very well be the reason that the county medical society has become all steamed up with Operation Hometown.

It all started last May when the county president, Raymond Baldwin, M.D., asked Eugene H. Betlach, M.D., to attend the National Medical Legislative Conference where Operation Hometown was given its debut by the American Medical Association.

Doctor Betlach returned to the Rock County Medical Society with a report on the activities of the Conference and the membership immediately voted a special assessment of $20.00 which made available a fund of $2,000 to implement Operation Hometown.

Eighty per cent of the Rock County doctors have also volunteered to participate in one of the six committees that make up this legislative program. Those doctors have also agreed to hold county medical society meetings during the summer months for the purpose of organizing Operation Hometown and becoming expertly familiar with the new King–Anderson Bill which is officially named the Hospital Insurance Act of 1963.

At present all committees are meeting and have completed their basic plans. Vast quantities of literature have been made available to all the doctors in the county. Speakers engagements are being arranged and a panel consisting of a college professor in economics, a hospital administrator, and a local doctor have been organized. The panel approach assures the audience that the King–Anderson Bill is not opposed only by organized medicine.

Committee appointments to implement Operation Hometown include:

E. H. Betlach, M.D.
E. W. Reinardy, M.D.

I. Speakers Bureau
M. J. Roesler, M.D.
J. L. Babb, M.D.

II. Newspapers, Radio and TV
J. R. Schroeder, M.D.
H. A. Raube, M.D.

III. Material Distribution
W. H. Pollard, Jr., M.D.
J. F. Holmes, M.D.
E. F. McNichols, M.D.

IV. Letter Writing
E. T. Jones, M.D.

V. Enlisting Allies
C. M. Carney, M.D.
M. B. Llewellyn, M.D.

VI. Congressional Contact
R. M. Baldwin, M.D.
P. R. Sholl, M.D.

Earl R. Thayer: Friend of Medicine

Earl R. Thayer, assistant secretary of the State Medical Society of Wisconsin, is leaving his present position to enter private business in his home-town of Waterloo, Wisconsin. In the sixteen years since he first came to the Society, Earl has become identified with many activities of our organization, not only in a professional capacity as a publicist, but also in a personal way through his sincere subscription to the cause of scientific medicine.

Coming to the State Medical Society as a young man, he soon advanced to the position of assistant secretary, and as such he became Mr. Crownhart's right hand man. He served also as executive secretary of the Wisconsin Public Health Council and as a member of numerous state committees dealing with health care and public welfare problems. He spent a large measure of his own time in travelling about the state to speak out against health fads, frauds and fallacies. His outspoken abhorrence of quacks, cultists and charlatans was well known and universally applauded.

Earl made a great contribution to the progress of the State Medical Society through his service as assistant managing editor of the *Wisconsin Medical Journal*. As part of the team that produces a monthly publication of integrity and financial stability his departure can be tolerated only because of the presence of a competent and trained successor, Mrs. Mary Lytle Angell.

All members of the Society join in wishing Earl R. Thayer as great success in his new venture as he enjoyed with our organization.—D.N.G.

P.S. by CHC

Doctor Goldstein has contributed a fine page of thanks to Earl Thayer. To all that he has said I add my profound "thank you" to Earl, and on behalf of the entire staff wish him the best of luck in his new endeavors.

ARE VERBAL Rxs TO A PATIENT—ADVISABLE?

It's 9 p.m. A physician's phone rings. It is Mrs. Jones, his patient. She tells him that she has a cough and that her temperature is normal. Her request: "Can you tell me what medicines I can take now, doctor? I'll probably see you tomorrow."

This situation—and many others like it—brings up this question: Should the physician give drug information verbally to the patient?

A just-completed national survey—conducted among pharmacists by AMERICAN PROFESSIONAL PHARMACIST magazine—points clearly to the following answer:

"*In the interest of the patient's health and safety, the physician should write prescription orders—or phone them to a pharmacist.*"

More significant than the answer itself are the reasons for the answer. The study clearly shows that there are at least 6 specific reasons why verbal prescriptions—given directly to the patient—are generally not advisable:

Reason No. 1: With respect to verbal drug information, one of the problems encountered is *sound-alike* names of drugs. For example, when the patient is given the name of a drug, the patient too often misspells or mispronounces it—when relaying it. As a result, the patient can actually take the wrong medicine . . . or, more frequently, not obtain it at all, because the pharmacist cannot interpret the request.

Reason No. 2: Drugs are available in several forms and strengths. Although the patient may have the correct name of the drug, she may not remember the form or the strength. As a result—because she is too embarrassed to phone the physician again—the patient may not even obtain the medication.

Reason No. 3: Very often, a patient will forget the verbal dosage a physician prescribed for her. She will not remember, for example, whether she should take the medicine "before meals" or "after meals" . . . or whether she should take it every 3 hours or 3 times a day.

Reason No. 4: In cases where the patient correctly recorded or remembered the name of the drug, it might turn out to be an "Rx only" drug . . . and the pharmacist is unable to sell it without an Rx. The patient may then become angry at the physician and the pharmacist—for the delay and the inconvenience.

Reason No. 5: When the patient knows the name of a drug that was prescribed for her, she might—as a special "favor" to a friend—suggest that the friend take the medicine for a "similar condition." This potentially-dangerous, patient-to-patient "diagnosis" is *unlikely* to occur if the Rx is written.

Reason No. 6: A prescription given orally to a patient eliminates an exact written Rx record—

Continued on page 364

Minutes of Council Meeting

Milwaukee, May 5, 1963

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 2 p.m. on Sunday, May 5, 1963, at the Schroeder Hotel in Milwaukee.

All voting members of the Council were present. Officers and others present were President Hill, President-elect Egan, Treasurer Weston, Speaker Callan, Vice Speaker Carey; Doctors Simenstad, Bernhart, and Galasinski, AMA Delegates; Doctors Collentine and Picard, Alternates; Past President Sorenson; Doctors Neupert, State Health Officer; F. E. Gehin, reference committee chairman; J. L. Weygandt and W. F. Smejkal representing the Division on Safe Transportation. Staff and consultants: Messrs. Crownhart, Thayer, Hansen, Toser, Gill, White, Tiffany, Murphy; Mrs. Anderson and Miss Pyre. Mr. John Kluwin, President, State Bar of Wisconsin, and special counsel for the Society, was present for one order of business.

2. Approval of Minutes

There being no additions or corrections, the Chairman declared the minutes of the February regular and April special meetings approved as distributed.

3. Financial Report to House of Delegates

Mr. White discussed the summary report by Donald E. Gill & Co. as to all activities of the Society which had been prepared for the House of Delegates.

On motion of Doctors Nordby–Lokvam, carried, the Council transmitted the report to the House of Delegates.

4. Report of Commission on Medical Care Plans

Doctor Dessloch commented on the annual report of the Commission distributed with the delegates handbook, and the last financial statement (February) sent to councilors and officers.

He then presented a statement proposing to the House of Delegates, with endorsement of the Council, a conference on the extension of voluntary health insurance to be held at the State Medical Society in the fall of 1963.

On motion of Doctors Dessloch-Blanchard, carried, the Council adopted the proposal and forwarded it to the House of Delegates. (See House proceedings, supplementary report of the Council.)

Doctor Kief asked the status of the dental rider and Doctor Dessloch indicated it was in process but had not reached the point that a contract could be presented.

5. Report of Division on Safe Transportation

The report of this division of the Commission on State Departments had not been forwarded to the House pending opportunity for the Council to review the matter of implied consent which it had earlier returned to the division for further consideration. Doctors Weygandt and Smejkal urged Council approval of the division's recommendation that the State Medical Society of Wisconsin endorse the principle of implied consent for chemical tests for intoxication and that specific legislative proposals be evaluated and considered for active support by the Society.

Doctor Willson made a motion to that effect and it was seconded by several. There was lengthy discussion and reference to bills in the Legislature on the subject. The Chairman stated that the division was requesting endorsement in principle, and specific legislative proposals would be reviewed by the Commission on Public Policy.

The motion passed by a vote of 11–9, and the division's report was forwarded to the House.

6. Podiatry

Mr. John Kluwin reviewed the background of the Society's suit against the Insurance Commissioner challenging his ruling to the effect that Wisconsin Physicians Service must provide benefits for services rendered by podiatrists where such services are also rendered by physicians and surgeons. He reported that it was still before the court with no decision rendered on the demurrer to the State's answer in the suit for declaratory relief brought in November, 1962.

7. National Office of Vital Statistics Surveys

Carl N. Neupert, M. D., State Health Officer, discussed with the Council four proposed studies by the National Office of Vital Statistics in which Wisconsin's share of the total cases involving a "Follow-back" inquiry would amount to about 650.

On motion of Doctors Bell-Nordby, carried, the Council approved participation in the surveys as outlined.

On motion of Doctors Bell-Dessloch, carried, the Council expressed its gratitude to Doctor Neupert for his cooperation in consulting with it.

8. Chiropractic

The question of a county making payment for chiropractic services under the Wisconsin Workmen's Compensation Act was raised last year in Dunn County and referred to the Attorney General.

The opinion of Attorney General Reynolds rendered in June of 1962 and only recently coming to the attention of the Society was received by the Council for information.

9. Executive Committeee of the Council

On motion of Doctors Nadeau-Lokvam, carried, past action of the Council in specifying the membership of its Executive Committee was amended to include the vice-chairman of the Council.

10. Commission on State Departments

By separate motion duly made, seconded and carried, the following were elected to the Commission on State Departments for one year terms:

General Chairman:
T. W. Tormey, Jr., M.D.

Vice Chairman:
L. M. Simonson, M.D.

Division Chairmen:
A M. Hutter, M.D.—Aging
H. A. Anderson, M.D.—Chest Diseases
J. W. Nellen, M.D.—Handicapped Children
John R. Evrard, M.D.—Maternal and Child Welfare

Charles Wunsch, M.D.—Nervous and Mental Diseases
H. W. Carey, M.D.—Public Assistance
Paul Dudenhoefer, M.D.—Rehabilitation
R. B. Windsor, M.D.—Safe Transportation
L. M. Simonson, M.D.—School Health
Meyer S. Fox, M.D.—Visual and Hearing Defects

11. Conference on Health Fads and Fallacies

Councilors and officers in attendance at the first such conference held at the Society in April gave their reactions which were quite favorable. It was suggested that if the conference is repeated another year, it be held somewhere out in the state to draw a wider audience.

Doctor Willson spoke to the point that more physicians should take it as a responsibility to attend these affairs at the Society to which the public is invited.

Chairman Fox said these thoughts would be incorporated in future plans.

12. Hospital Achievement Award

No nominees for this award instituted in 1960 by the Commission on Hospital Relations and Medical Education were received in 1963. It was suggested that perhaps the mechanisms of selection should be re-evaluated.

Doctor Nordby expressed the consensus of the Council that the award, to have meaning, should be given only when deserved, not necessarily every year, and a change in mechanism is not needed so much as keeping up the standards.

13. Aaron Bohrod Paintings

On motion of Doctors Nordby-James, carried, the Council voted its thanks to the Eli Lilly Company for gift of the seven Bohrod oil paintings to the CES Foundation of the State Medical Society.

14. Resolution on Pathology

Doctor Van Hecke introduced a resolution for the Section on Pathology concerning the practice of pathology and the provision of health insurance benefits in the medical service rather than the hospital contract of Wisconsin Physicians Service. His motion that it be forwarded to the House of Delegates for consideration was seconded by Doctor Ekblad.

Doctor Dessloch said that the Commission on Medical Care Plans had no quarrel with the philosophy of the resolution and it is its avowed purpose to do exactly what the resolution proposed. He pointed out, however, that not all installations have both ends of the contract, but the Commission was moving toward the goal of having all medical services provided through the surgical-medical contract and rates.

Doctor Van Hecke said the intent was to have approval in principle that pathology is the practice of medicine, and for the Commission to continue its work in the direction indicated.

An amendment by Doctor Frank, seconded and carried, added radiology to the resolution.

Doctor Van Hecke accepted a revision in the original resolution proposed by Doctor Dessloch to the effect that WPS reaffirm its position that these services are medical, and also the recommendation that the resolution be forwarded to the House with the suggestion that it be referred to the Commission for further implementation. The original motion was carried as amended. (See Resolution 9, House proceedings.)

15. Wisconsin Health Council, Inc.

The Board of Directors of the Wisconsin Health Council proposed Society publication to the medical profession of a statement on vaccination against smallpox.

The Council felt the need of a minor revision in the language of the statement before it could be endorsed, and suggested that it be returned for rephrasing with medical advice.

16. External Cardiac Massage

Doctor Nordby introduced for a member of the Dane County delegation a resolution on external cardiac massage which was forwarded to the House on motion of Doctors Dessloch-Nordby, carried. (See Resolution 8, House proceedings.)

17. O. A. Mortensen, M.D.

The following letter from Doctor Mortensen to the Secretary was read into the record:

"Each year when my membership card arrives I am reminded of the privilege of Honorary Membership in the State Medical Society of Wisconsin. My participation is limited primarily by virtue of a preoccupation with anatomy and administration but I sincerely appreciate the increased opportunity for association with former students and colleagues which my membership provides."

18. Management Survey

Doctor Callan inquired as to the independent review of the survey report by special legal counsel, Mr. Robison. Mr. Crownhart said that he had no written report on the point of possible libelous material, and felt personally that while it was contentious and subject to interpretation, there was no objection to its circulation to the House of Delegates. Doctor Fox said that Mr. Robison would be in Milwaukee later, and if there was any question as to its contents he would call a special meeting of the Council.

The Council recessed from 5:30 until 8 p.m.

19. Kerr–Mills Legislation

Doctor Hill read a statement proposed by the Executive Committee for consideration by the House of Delegates with reference to implementation of the Kerr-Mills law in Wisconsin.

On motion of Doctors Nordby-Mason, carried, the statement was approved as edited. (See House proceedings, supplementary report of the Council.)

20. Report of Executive Committee

Secretary Crownhart presented the committee's report as follows, with Council action noted:

"The Executive Committee met from 7:45 to 11:30 p.m. on Saturday, May 4, and again for two hours the morning of May 5. A considerable amount of its work was routine, not involving any matter of policy. These matters are reported to the Council:

"a. Meeting with Wisconsin Hospital Association

It has been suggested by R. C. Frank, M.D., that there be a joint meeting with the board of trustees of the Wisconsin Hospital Association and the Council of the State Medical Society. The committee recommends that this be done and suggests the July meeting of the Council. Preliminary information from the Wisconsin Hospital Association indicates that this is entirely feasible and it will take advantage of the opportunity. The Executive Committee encourages Doctor Frank to meet with Mr. Guntner

and develop an outline of discussion that will be mutually advantageous."

Council action: Approved on motion of Doctors Dessloch-Van Hecke, carried.

"b. By way of information to the Council, the Executive Committee reported:

(1) Approval of a news release on the tax impact of the King-Anderson bill over the signature of Doctor Hill, President. This has been released to the press.

(2) The interim report of the AMA's Commission on the Cost of Medical Care was reviewed, and the committee believes that a final report will be forthcoming at the Atlantic City meeting and suggests that all councilors watch the AMA NEWS for further developments.

"(3) It proposes cooperation with the Wisconsin Jaycees in assisting in a membership drive, and notes the developments in accreditation of nursing homes serving the aged which it will follow closely and report to the Council on a subsequent occasion.

(4) It received from the secretary's office a statement of the State Board of Medical Examiners on the matter of division of fees and expresses some doubt as to the advisability of the language in that statement relative to consent of the patient. The complete statement will be distributed to the Council in due course.

(5) It reviewed and recommends that the Council affirm a statement of the Commission on Hospital Relations and Medical Education that the operation of the State Laboratory of Hygiene continue as a joint responsibility of the University of Wisconsin and the State Board of Health."

Council action: Recommendation approved on motion of Doctors Ekblad-Dessloch, carried.

"(6) It reports that in July the committee intends to meet with representatives of the Section on General Practice in further discussion of the matter of division of fees, membership requirements for sections, and similar matters. No decisive action was taken at its current meeting, but details will later be reported to the Council."

"c. Joint Sponsorship of Postgraduate Teaching Programs

It is the policy of the State Medical Society that those appearing on its programs or offering papers for publication in the Wisconsin Medical Journal should be members of the State Medical Society.

However, there are occasions when the State Medical Society may enter into joint sponsorship of postgraduate training programs in which some members of other sponsoring organizations may not be members of the State Society.

Joint sponsorship encourages integrated planning, the avoidance of overlapping courses, and more stimulating programs.

Where an independently organized group cooperates with the State Medical Society to that end, the Executive Committee believes and so recommends to the Council that the policy relating to membership is not applicable inasmuch as the program is not exclusively within the jurisdiction of the State Medical Society."

Council action: Recommendation approved on motion of Doctors Dessloch-Lokvam, carried.

"d. Honorary Membership

The Executive Committee nominates S. A. Morton, M.D., of Milwaukee, for honorary membership in the State Medical Society of Wisconsin, a distinction already accorded him by the Medical Society of Milwaukee County. Doctor Morton is now in Lebanon."

Council action: Approved on motion of Doctors Nordby-Schulz, carried.

"e. Television Series on Health Fads and Fallacies

As a result of the recent conference on Health Fads and Fallacies, the state TV station proposes a series of programs in which the cooperation of the State Medical Society would be required but as to which the expense would be nominal.

The Executive Committee feels that such a program kinescoped for other TV stations in the state carries on the purpose of the Conference on Health Fads and Fallacies and that the staff and appropriate committees should continue exploring appropriate ways in which this can be carried into effect."

Council action: Approved on motion of Doctors Houghton (J. H.)-Wilson, carried.

"f. Extension Course in 'Legal Problems in the Practice of Medicine'

The University of Chicago, which has long been prominent in extension courses designed for those with special training, for reasons unimportant to this report, is discontinuing a number of these extension courses, not for lack of success but to better concentrate the activities of that institution in certain specialized fields.

The Extension Division of the University of Wisconsin has been informed that the University of Chicago would release its special course in 'Legal Problems in the Practice of Medicine' to Wisconsin to be continued much in the same manner as at Chicago.

The Extension Division consulted with both the president and the secretary of the State Medical Society. The program seems adequate and of very considerable value, particularly to the newer practitioner of medicine. The Executive Committee commends the University for its interest and assures it of its cooperation in the development of this program, providing the Council so approves."

Council action: Approved on motion of Doctors Nordby-James, carried.

"g. Legislation

While there are many other matters on the Executive Committee's agenda, including meetings with state officials, the development of certain specialized programs in connection with the 1964 Work Week of Health, the committee spent a very considerable amount of time on matters of legislation which it now reports to the Council:

"(1) Nursing Laws

The Wisconsin Nurses Association is sponsoring certain legislation intended to strengthen the public health status of its activities. Both the Commission on Public Policy and staff have been in conference on the subject, and can now report that the bills are in form which should receive the support of the Society, and the Society should stand with the State Nurses Association in opposition to the proposal to permit a person who has attended a professional nursing school for one year and worked as a nurse in a hospital two years to be eligible for examination and licensing as a trained practical nurse.

The Executive Committee is of the belief that this would tend to lower the standards and abilities of those trained or licensed as practical nurses and agrees that the position of the State Nurses Association in this respect should be supported."

Council action: Approved on motion of Doctors Dessloch-Houghton (J. H.), carried.

"(2) Regulation of the Blue Plans

There are three bills relating to the Blue plans, the effect of which would be to place them entirely under the control and regulation of the Insurance Commissioner, and more specifically, under his control as to rates.

A limited amount of supervision was voluntarily accepted by the Society which supported a law to that effect a few years ago. The Insurance Commissioner has not disclosed any circumstance which should support his request for added power, and the Executive Committee is of the opinion that rate control would tend to stifle further development of these programs into new and somewhat untried fields.

Therefore, the Executive Committee recommends opposition at this time, there being no disclosure of any need for such legislation."

Council action: Motion of Doctors Willson-Mason, carried, to oppose the bills.

"(3) Hospital Licensing

The Executive Committee is happy to report that negotiations with both the State Board of Health and the Wisconsin Hospital Association have led to a satisfactory amendment to the hospital licensing proposal to the end that the constituency and activities of the medical and surgical staff will not be inhibited. The Executive Committee therefore believes that the proposal can now be supported as adequate in public health interest."

Council action: Approved on motion of Doctors Blanchard-Kief, carried.

"(4) Utilization of County Institutions

The matter of institutional care of those with tuberculosis or pulmonary disease has undergone radical changes in recent years to the point that most are served through outpatient facilities of the county institutions.

This tends to develop these facilities into broader areas of diagnosis and while the matter comes before the House of Delegates through the report of the Division on Chest Diseases, the Executive Committee believes that these diagnostic activities should be very carefully evaluated that they not be purposeless. Since the Commission on State Departments of which the Division is a part is a committee of the Council, the Executive Committee recommends to the Council that it advise the Commission on State Departments to thoroughly and carefully review proposed changes of service in this area."

Council action: Approved on motion of Doctors Lokvam-Nadeau, carried.

21. Organization of Commission on Public Policy

At this point Doctor Nadeau proposed for study the establishment of various divisions of special interest within the Commission on Public Policy as in the organization of the Commission on State Departments. He felt this would provide a mechanism to have a greater number of physicians active on legislation at the appropriate times.

On motion of Doctors Dessloch-Hollenbeck, carried, the proposal was referred to the Planning Committee of the Council for implementation and action, including the addition of a fiscal note.

22. Dues for 1964

Doctor Callan inquired whether there was any thought of proposing an increase in dues of the House of Delegates. Doctor Fox replied that in view of the management survey report to be made to the House, he did not feel that any discussion of a change in dues was indicated until after the report and perhaps not until the fall meeting.

23. Adjournment

The meeting adjourned at 9:15 p.m.

Approved

C. H. Crownhart
Secretary

James C. Fox, M.D.
Chairman of the Council

VERBAL Rxs *Continued from page 360*

stored at a pharmacy—as to what medicine was actually prescribed. This record can come in very handy—with respect to protecting the physician against the ever-increasing number of malpractice suits.

From the above 6 reasons, it appears rather clear that *written* prescriptions are in the best interest of both the public and the physician. Aside from preventing errors, a written prescription will generally avoid any delay in getting the proper medication . . . to the proper patient . . . at the proper time.

Consequently, when medication is to be prescribed—pursuant to a phone call or even during an office visit or house call—a written prescription is advisable.

If a written Rx is inconvenient or not possible, it would be best for the physician to say to the patient: "What is the phone number of your pharmacist? I will phone a prescription to him." Or perhaps the physician can say: "Please ask your pharmacist to phone me."

Drug orders, therefore, are best communicated directly from the physician to the pharmacist—whether the communication be via a written prescription or via the telephone.—Irving Rubin, Ph.G., Editor, *American Professional Pharmacist.*

FILM—OBESITY: SOME HIGHLIGHTS OF MANAGEMENT

A new film entitled, "Obesity: Some Highlights of Management," is being made available by E. R. Squibb & Sons, Division of Olin Mathieson Chemical Corporation. The lecture-type film, delivered by Dr. Garfield G. Duncan, Professor of Medicine, University of Pennsylvania, points out that obesity is a leading menace to health and longevity and is one of the greatest challenges in the practice of medicine. Designed for viewing by professional medical audiences, the film highlights some methods employed by Dr. Duncan and his colleagues in the management of obesity. Dr. Duncan is also Director, Medical Divisions, Pennsylvania Hospital and Benjamin Franklin clinic.

The black and white sound film runs 20 minutes and is available at no charge from all Squibb regional offices, or by writing the New York office at 745 Fifth Avenue.

the wisconsin medical journal

VOLUME 62/NUMBER 9 SEPTEMBER 1963

Clinical Use of Radioisotopes For Organ Scanning

By ROBERT C. MEADE, M. D. and DONALD A. FRANKLIN, M. D.

Milwaukee, Wisconsin

■ BECAUSE radioactive compounds are among the more recent tools available to the diagnostician, new and clinically useful procedures are constantly being sought. In the past few years, great strides have been made in improving techniques of organ scanning. At present, a modern radioisotope laboratory with proper equipment is able to produce useful diagnostic scans of the brain, thyroid, liver, spleen, and kidneys as well as the blood occupying space of the heart and abdominal aorta. Techniques for scanning the pancreas using Se^{75} selenomethionine are being developed.[1] The detection of metastatic bone tumors using strontium[85] or calcium [47] [2,3] appears promising. This paper will present techniques for scanning with illustrative case histories and scans of the brain, kidney, liver, and spleen.

Recent improvements in organ visualization have been due mainly to the development of improved radiation detection equipment, the production of more suitable isotope labeled compounds and better understanding of factors important in producing good scans. The advances in detection equipment and improved methods of presentation of data have perhaps been largely responsible for the recent interest in organ scanning. Early brain tumor localization studies consisting of multiple counts of contralateral areas of the skull were much less meaningful than, for example, the two-dimension black and white photoscan which can be superimposed upon skull x-ray films of the same patient.

The scanner used in this laboratory is the Picker Magnascanner.* The scintillation detector with appropriate collimator passes back and forth over the organ to be visualized and the signal passes through a single channel spectrometer to a count rate meter and is recorded simultaneously as both a dot scan on electrically sensitive paper and a photoscan on an x-ray film. The former dot scan has the advantage of direct visualization during the scanning procedure, whereas the photoscan permits contrast enhancement.

Thyroid. Thyroid scanning following a tracer or therapeutic dose of I^{131} has been the subject of numerous papers and will not be illustrated here. Scanning is usually done

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* Picker X-Ray Corporation, White Plains, N. Y.

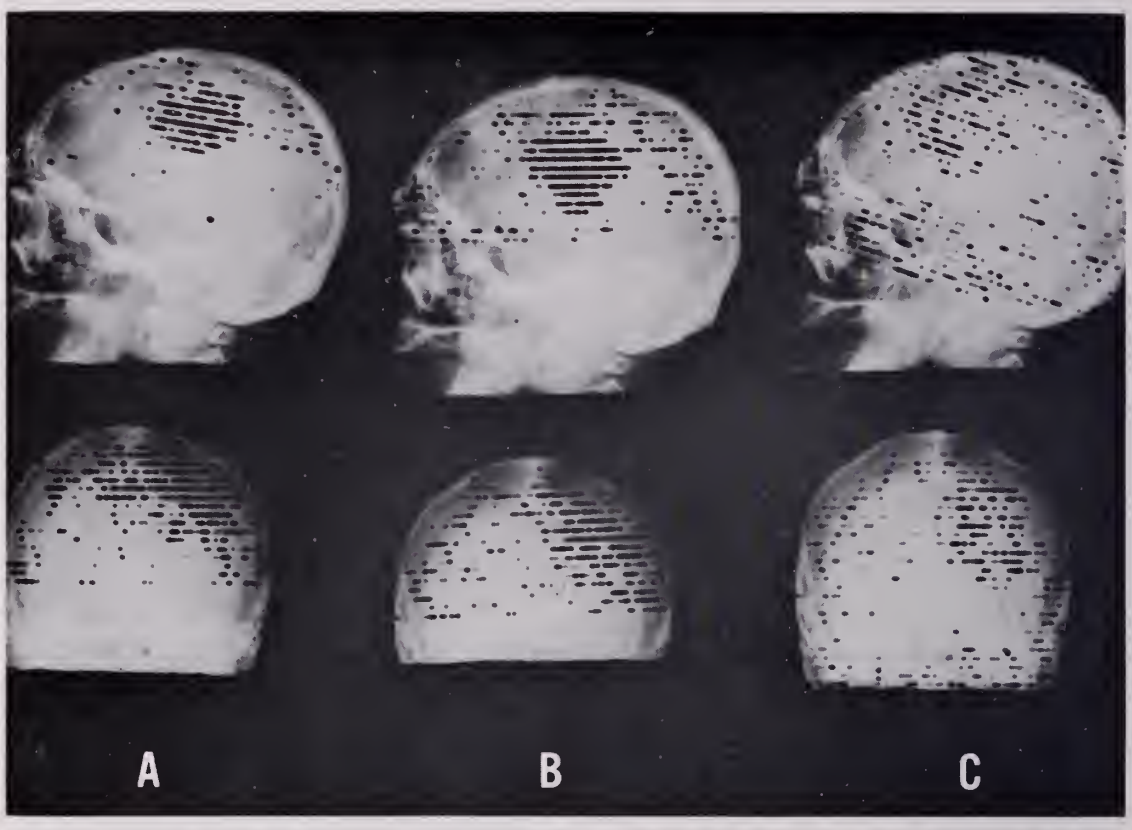

Fig. 1—Case 1: Recurrent astrocytoma of left frontal parietal area. (a) Initial study showing recurrence. (b) Scan three months later following chemotherapy, showing no change. (c) Four months following surgery; tumor is decreased.

24 hours after the radioiodine is given, and with the aid of a 31-hole focusing collimator hot or cold nodules of one-half centimeter diameter or greater can be detected. Another radioiodine, I^{125}, has some advantages. Since this is a low energy x-ray and gamma emitter, shielding and collimating is more easily accomplished.[4] To what extent it will replace I^{131} remains to be seen.

Brain. Brain tumor localization depends upon concentration of the radioactive material in or about the tumor itself. This localization is felt to be due to the loss of the normal blood-brain barrier which occurs in neoplasms, abscesses, and subdural hematomas. Blau and Bender[5] first introduced the use of chlormerodrin (Neohydrin) tagged with Hg^{203} and this compound is currently employed in this laboratory for brain and kidney scans. Some workers prefer the use of radioiodinated serum albumin but the radiation characteristics of Hg^{203} and biologic handling of the carrier appear to make the Hg^{203} superior to $Iodine^{131}$. Ten microcuries per kilogram is given intravenously three to five hours prior to scanning. The radiation to the patients' kidneys following a brain scan can be reduced 1/3 by the administration of 1 ml. of meralluride sodium solution (Mercuhydrin) 24 hours before the scan. The ability of I^{131} labeled polyvinyl-pyrrolidone (PVP) to localize in brain defects has been demonstrated in animals.[6] In a few patients with brain tumors demonstrated with chlormerodrin-Hg^{203}, a follow-up study was done in this laboratory using PVP-I^{131}. In each case, the mercury scan was far superior. A few illustrative cases to demonstrate the value of brain scanning will be presented. Chlormerodrin-Hg^{203} was used in each case. It is noteworthy that pneumoencephalograms with their attendant hazards and discomfort have not been necessary.

Case 1. G.A. (age 43) had an astrocytoma of the left frontal lobe partially removed in 1959 with subsequent x-ray therapy. He was readmitted in 1962 with headache, right hemiparesis, numbness, and Jacksonian seizures. His scan (Fig. 1-a) revealed a focus of increased activity in the left

frontal area. The left internal carotid artery was cannulated and infusions of methotrexate and 5–FU were carried out with little clinical benefit. A repeat scan (Fig. 1-b) revealed no change in the size of the tumor. He, therefore, had a repeat craniotomy with removal of much residual tumor in the area indicated on the scan. The patient was much improved after surgery. Seizures were controlled, his speech and strength improved, and he was discharged. A scan four months postoperatively (Fig. 1-c) showed a decrease in tumor size.

Case 2. M.B. (age 68) was hospitalized because of a "stroke" with left hemiparesis and Jacksonian seizures. His chest x-ray film revealed right hilar enlargement. Bronchoscopy and scalene node biopsy were negative. The spinal fluid protein was 82 mg. per 100 ml. The brain scan (Fig. 2) revealed a focus of increased activity in the right parietal area and postmortem examination confirmed the diagnosis of bronchogenic carcinoma with cerebral metastasis to the right parietal area.

Case 3. F.Z. (age 41) had a four month history of headaches, nausea, and ataxia. Examination revealed bilateral papilledema and retinal hemorrhages, hyperactive deep tendon reflexes, positive Babinski sign, and ankle clonus bilaterally. The brain scan (Fig. 3) revealed a tumor in the left frontal area as did an angiogram, and a craniotomy revealed a benign meningioma.

Case 4. S.H. (age 67) had a single episode of headache, confusion, syncope, and a convulsion. He felt well on the following day. Examination was completely negative except for equivocal slight widening of the left palpebral fissure. A spinal fluid protein was 96 mg. per 100 ml. and an electroencephalogram revealed some slow wave activity in the right frontal-temporal area. Bilateral carotid angiograms were normal. The brain scan (Fig. 4) clearly revealed a focus in the right frontal area. A right frontal fibromatous meningioma was excised, and the patient was discharged one week later.

Case 5. A.P. (age 55) was admitted because of confusion. There were no localizing neurologic findings. The chest x-ray film revealed a right hilar mass. His spinal fluid protein measured 245 mg. per 100 ml. and an electroencephalogram revealed an abnormal focus on the left side. A carotid angiogram was normal. The brain scan (Fig. 5) revealed a large focus of increased activity in the left occipital area. Postmortem examination revealed bronchogenic carcinoma with diffuse metastasis. In addition to the occipital lobe tumor shown on scan, a right temporal and a cerebellar tumor were not detected. Both were less than 1.5 cm. in diameter.

This inability to localize all tumors has been our experience with metastatic brain lesions. For every metastatic lesion visualized on scan there have been one or more too small to detect. Tumors less than 2 cm. in diameter are rarely seen, and the favorable results in detection of primary brain tumors suggests the large size of a lesion before the patient seeks medical aid or is extensively studied for possible brain tumor.

Fig. 2—Case 2: Metastatic bronchogenic carcinoma to right parietal area.

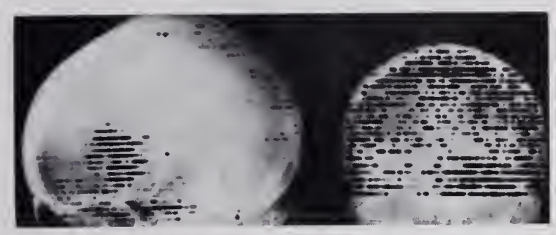

Fig. 3—Case 3: Left frontal meningioma.

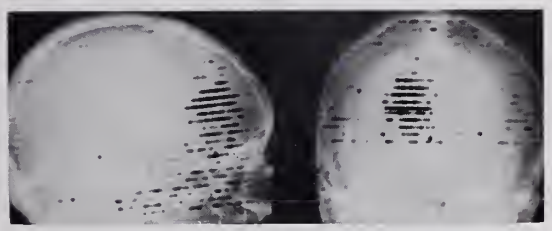

Fig. 4—Case 4: Right frontal meningiama.

Fig. 5—Case 5: Metastatic bronchogenic carcinoma.

Liver. Three suitable isotopes exist which can be used for liver scans. These are colloidal radioactive gold^{198}, which is taken up by the von Kupffer cells, and rose bengal or thyroxine tagged with Iodine^{131}, which concentrate in the hexagonal cells of the liver. None of these isotopes is ideal. The high energy of the gold is difficult to collimate, and the rose bengal clears the liver so rapidly that the scan must be completed one hour after injection at which time the rose bengal laden bile is entering the intestinal tract and concentrating in the gallbladder.

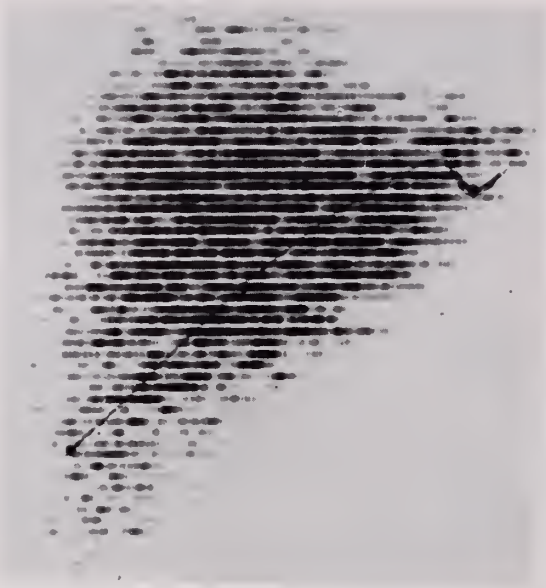

Fig. 6—Case 6: Normal liver.

Fig. 7—Case 7: Portal cirrhosis, chronic chalecystitis and choledacholithiasis. Note hepatomegaly and spleen.

Fig. 8—Case 8: Multiple filling defects in liver due to metastatic mucinous adenocarcinoma.

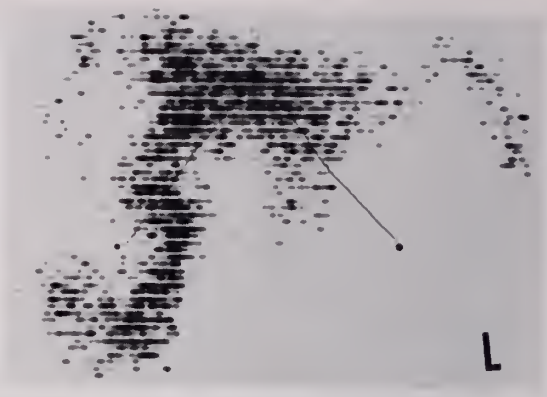

Fig. 9—Case 9: Liver largely replaced by metastatic adenocarcinama.

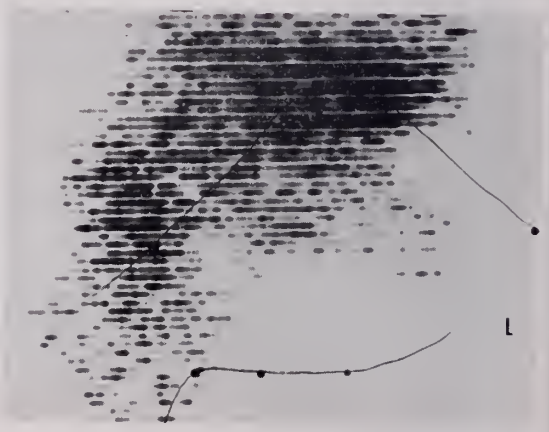

Fig. 10—Case 10: Hepatamegaly with multiple filling defects due ta aat cell carcinoma. Biopsy of large defect at lower barder yielded diagnasis.

Colloidal gold remains in the reticuloendothelial system and scans can be done any time from 15 minutes to 24 hours after injection. One-hundred to 150 μc. of the isotope give adequate scans. Cases demonstrating various aspects of liver scanning follow.

Case 6. C.W. (age 62) had an adenocarcinoma of the rectum at the 5-inch level. His liver scan (Fig. 6) revealed normal size and configuration of the liver and at surgery the liver was grossly free of metastases.

Case 7. L.B. (age 69) had a previous diagnosis of cirrhosis and three weeks prior to entry he developed right upper quadrant abdominal pain, emesis, pruritis, light stools, and dark urine. Examination revealed marked icterus and hepatomegaly. His alkaline phosphatase ranged from 53 to 80 Bodansky units, total. The liver scan (Fig. 7) revealed some enlargement with normal configuration and no filling defects. The spleen was also visualized. Laparotomy revealed chronic cholecystitis and choledocholithiasis. Note that the scan was of excellent quality despite the hepatic parenchymal impairment,

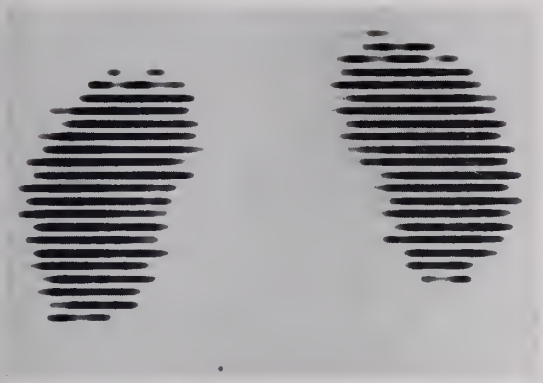

Fig. 11—Normal kidney scan.

Fig. 12—Case 11: Renal ischemia. Absent function lower pole of right kidney.

Fig. 13—Renal cyst, lower pole of left kidney.

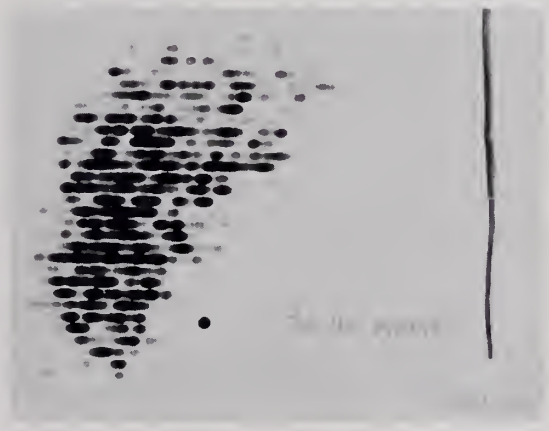

Fig. 14—Narmal spleen.

the uptake of the gold particles depending only upon the integrity of the von Kupffer cells.

Case 8. G.M. (age 67) entered the hospital because of increasing angina. Examination revealed the liver to be down 10 cm. His alkaline phosphatase was 11.1 Bodansky units, and the stools were positive for occult blood. Complete gastrointestinal x-ray studies and an intravenous pyelogram were interpreted as normal. His liver scan (Fig. 8) revealed mottled areas of infiltration throughout the liver. A needle biopsy at the site of a large filling defect revealed a mucinous adenocarcinoma probably originating in the biliary tract, pancreas, or gastrointestinal tract.

Case 9. R.H. (age 36) had rectal bleeding for several months and examination revealed slight hepatomegaly. Proctoscopy revealed adenocarcinoma of the rectum. His alkaline phosphatase was 18.7 Bodansky units. The liver scan (Fig. 9) revealed almost complete replacement of the liver by large filling defects. A palliative resection of the tumor was done and the liver was found to be filled with huge metastatic lesions.

Case 10. E.H. (age 38) entered with anorexia, emesis, constipation, and weight loss. Examination revealed 5 cm. hepatomegaly. The alkaline phosphatase was 24 Bodansky units and the bromsulphalein 22%. A chest x-ray film revealed multiple round nodular lesions, and complete gastrointestinal, gallbladder, and kidney x-ray studies were normal. A liver biopsy revealed fatty metamorphosis, and a cell block from fluid on a second liver biopsy revealed some atypical malignant cells. A liver scan (Fig. 10) revealed an enlarged liver with huge filling defects. A third liver biopsy performed in the area indicated by the scan revealed a metastatic undifferentiated oat cell carcinoma, probably bronchogenic in origin. The patient was treated with chemotherapy.

The liver scan is a useful preoperative tool. When very obvious metastasis is demonstrated, no more than a palliative surgical

procedure can usually be expected. The value of the liver scan in localizing the most profitable area of biopsy is demonstrated in Cases 8 and 10.

Kidney. Chlormerodrin is concentrated in the kidney and renal scans are performed approximately one hour after the injection of 50 μc. of the mercury^{203} tagged drug. This permits visualization of the renal parenchyma, whereas the excretory urogram defines the collecting system. In addition to localizing tumors and cysts, perhaps one of the important uses of kidney scans will be in visualizing areas of renal ischemia in cases of renal hypertension.

Figure 11 illustrates a normal kidney scan taken with the patient lying prone. In this position, the right kidney is usually more cephalad than the left.

Case 11. E.B. (age 65) developed morning headaches, dyspnea, and sudden hypertension during the past year. His blood pressure was 300/150. The blood urea nitrogen, urea clearance, phenolsulfonphthalein test, and phentolamine (Regitine) test were normal. An intravenous pyelogram revealed a normal collecting system, but the left kidney measured 13.5 cm. in length as opposed to 11.0 cm. on the right. Split kidney function revealed diminished volume on the right but equal sodium and chloride excretions. The kidney scan (Fig. 12) showed nonvisualization of the inferior half of the right kidney, and an aortogram revealed partial occlusion of the right renal artery.

Figure 13 is a scan of the left kidney of a patient with carcinoma of the prostate with metastases. The filling defect shown was due to a cyst in the lower pole which was found at autopsy.

Spleen. Although the spleen is sometimes visualized during a colloid gold liver scan, a more satisfactory study allows visualization of the spleen without interference by the liver. Such studies are possible using heat-denatured erythrocytes tagged with Chromium^{51}.[7] Red blood cells heated to 49.5 C. for 15 minutes are trapped by the spleen. A normal spleen scan 24 hours after injection of the tagged erythrocytes is shown in Figure 14.

Summary. Cases illustrating the clinical utility of organ scanning have been presented. This field of diagnostic medicine is rapidly expanding and at present, scanning of the thyroid, brain, liver, kidneys, and spleen is routine in many institutions. Current research studies may soon add the heart, lung and pancreas, and metastatic bone tumors to this list.

Radioisotope Service, Veterans Administration Center, Wood.

REFERENCES

1. Blau, M. and Manske, R. F.: Pancreas specificity of Se^{75} selenomethionine, J. Nuc. Med. 2:102–105 (Apr) 1961.
2. Fleming, W. H., McIlraith, J. D., and King, R. E.: Photoscanning of bone lesions utilizing strontium-85, Radiology 77:635–636 (Oct) 1961.
3. Corey, K. R., Kenny, P., Greenberg, E., and Laughlin, J. S.: Detection of bone metastases in scanning studies with Calcium-47 and Strontium-85, J. Nuc. Med. 3:454–471 (Nov) 1962.
4. Endlich, H., Harper, P., Beck, R., Siemens, W. and Lathrop, K.: Use of I^{125} to increase isotope scanning resolution, Amer. J. Roentgenol. 87:148–155 (Jan) 1962.
5. Blau, M., and Bender, M. A.: Radiomercury (Hg^{203}) labeled Neohydrin; new agent for brain tumor localization, J. Nuc. Med. 3:83–93 (Mar) 1962.
6. Tauxe, W. N., Sedlack, R. E., Pitlyk, P. J., and Kerr, F. W. L.: Preliminary report on localization of brain lesions with I^{131} labeled polyvinylpyrrolidone, Proc. Mayo Clin. 37:109–111 (Feb 14) 1962.
7. Johnson, P. M., Wood, E. H. and Mooring, S. L.: Splenic scintillation scanning, Amer. J. Roentgenol. 86:757–767 (Oct) 1961.

POSTHERPETIC NEURALGIA

Sehgal, Arjun D. and Gardner, W. James, The Cleveland Clinic Foundation, Cleveland, O., *Neurology* 12: 725 (Oct) 1962.

It is difficult to assess therapy in a disease such as postherpetic neuralgia, which may show spontaneous fluctuations and whose severity is hard to measure. Nevertheless, on the basis of the data presented in 30 cases of postherpetic neuralgia with follow-up at four months to two years, the authors feel justified in concluding that corticosteroids have no therapeutic value when administered by mouth or used epidurally or intradurally. However, in most cases, corticosteroids in procaine infiltrated into the involved skin provided temporary relief from pain more consistently than any other regimen.

Of the 30 cases, 12 were given local injections of either hydrocortisone (125 mg.) or methyl prednisone acetate (40 to 80 mg.) together with 0.5 or 1 per cent procaine. In this group, 2 had good permanent results, 5 had fair (complete relief lasting one week to one month) and 5 had poor results. Injections were repeated if pain recurred. For comparison, the remainder of the group was given local injections of procaine, intradural methyl prednisone acetate, epidural injections of procaine and hydrocortisone acetate, cortisone by mouth, dilantin, and vitamin B_{12}. In these, results generally were "poor" with only a few "fair" results. Thus local injections into the involved skin areas with corticosteroids and procaine even several months or years after the initial herpes episode seems to be the treatment of choice at present.

The Perilimbal Suction Cup: a New Method for Early Diagnosis of Glaucoma

By LAWRENCE L. GARNER, M. D., F. A. C. S., Milwaukee, Wisconsin

■ THE PERILIMBAL suction cup provides another method of studying the resistance to flow of aqueous out of the eye. As a method for the early diagnosis of glaucoma, it has a larger field of application than that provided by tonography. The original observations of Rosengren[1] in 1956 on the results of circumlimbal pressure to the eye led to the development of the apparatus and technique for clinical application.[2]

Tonography was introduced in 1950[3] and is now being widely used for the early detection of glaucoma. While not entirely free from error, it nevertheless is of value in the diagnosis, treatment, and evaluation of the glaucoma patient. It has given much information about the aqueous dynamics of the eye.

The perilimbal suction cup provides another method of study of the resistance to the flow of aqueous in the eye. The apparatus is simpler than that used in tonography. It is easier to operate and the data obtained easily interpreted. It is particularly advantageous in those instances where tonography cannot be performed. With the one-eyed patient, satisfactory tracings are difficult to obtain because the patient must remain at rest and maintain steady fixation of the eye while being tested. His eye must not move in any direction for four minutes. For most patients this is a difficult feat, when the only seeing eye is obstructed by the instrument. As a result, the tracings usually are unsatisfactory. When the suction cup method is employed, the patient may sit up or lie down. Movement of the eye will not alter the results.

Tonography is hazardous in the patient with nystagmus because the uncontrolled movement of the eye may cause damage to the cornea. With the new technique we can use suction cups without fear of corneal injury or the development of complications.

Many patients with congestive heart failure are orthopneic and cannot tolerate the recumbent position required for tonography. In these patients the perilimbal suction cup technique makes it unnecessary for the patient to lie down.

This method is ideally suited for the child who is not old enough to cooperate properly for the tonogram. We have obtained good tonograms in children as young as 6 years but only with the exceptionally good child. The perilimbal suction cup method eliminates the effects of crying or movement. The only precaution needed is that the arms of the child be immobilized so as to prevent the child from attempting to pull the apparatus from the eye.

An infrequent but serious source of difficulty in diagnosis is the hypotonus eye. This condition, found after surgery and in some diseases of the eye, results in softening of the eyeball so that an attempt to obtain information by ordinary means of recording tonography is difficult and the results usually inaccurate. The perilimbal cup method of examination gives accurate measurements in these and in patients whose eyes are distorted by corneal scar or other deformity, provided the perilimbal area is not involved.

It is apparent that the perilimbal suction cup is most suitable in those conditions where tonography cannot be employed, and in patients in whom tonography gives equivocal results.

Equipment Required. Figure 1 represents the instrument used at our Glaucoma Center, prepared for us by the Department of Physiology. An original model now in use at the Milwaukee County Hospital was purchased from Dr. Robert Schimek[5] who can be

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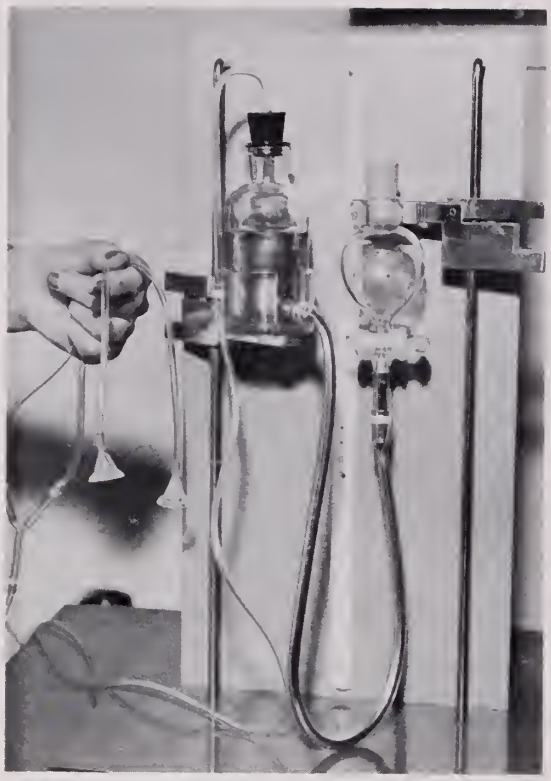

Fig. 1—Perilimbal suction cup apparatus.

contacted by anyone interested in the purchase of such equipment. Figure 2 presents a patient undergoing the test with the operator grasping the polyethylene tubes in preparation for removal when the assistant raises the right hand receptacle to break the vacuum.

Procedure. The patient is made recumbent and comfortable with tight clothing removed as in tonography. Ophthetic or similar local anesthetic is instilled into each eye, repeated about 15 seconds later. The intraocular pressure is now measured by tonometer. The two mercury receptacles are then adjusted so that almost all the mercury runs into the larger vessel on the left, permitting only a small amount of mercury to lie just above the stopcock in the vessel on the right. At this point the stopcock in the right hand vessel is shut. Since the bottle on the left is not moved, it is advisable to place some adhesive tape just under the clamp for the left hand vessel to prevent its moving inadvertently or accidentally. The bottle at the left is fixed at a level so that the upper level of mercury is at about 29 cm. on the height scale. We now move the right hand vessel down so that the level of mercury in the smaller receptacle is about 7 to 8 cm. below the level of the mercury in the larger vessel. This is done because, before suction is fully effective, the level of mercury will rise somewhat in the right hand receptacle towards equilibrium. About 3 lb. of mercury is required in the system and more than this is not recommended in order to prevent mercury from running out and spilling over the lower receptacle if one's attention is diverted when the stopcock is opened and the suction is inadvertently broken. The stopcock remains closed and the suction cups are slipped under each lid and carefully centered over the cornea so that they will exert their pressure uniformly on the perilimbal area of each eye. An assistant then opens the stopcock as the operator gently places the perilimbal suction cups onto the mid corneas and adds a little downward pressure to facilitate the hold of the cup. Once suction has been firmly established on each eye, the cups will be firmly held in position and will move along with the eye without affecting the test. Movements are, therefore, not restricted. The polyethylene tubes are now suspended from a support in order to prevent excessive drag on the eyes in any direction because of the attached suction cups and the pull from the polyethylene tubing to the instrument. At this time the two glass receptacles are adjusted so that the level difference between them is 5.0 cm. or slightly better.

Once the suction cups are applied and left in place the patient may sit or be recumbent to be comfortable. The suction is applied for 15 minutes following which the cups are removed and the intraocular pressure immedi-

Fig. 2—Patient with perilimbal suction cup in operation.

ately measured by tonometer using a single drop of local anesthetic before the test. To facilitate the removal of the perilimbal suction cups, the right hand vessel is raised by the assistant while the operator holds each tube leading to the cup. The raising of the right hand vessel causes mercury to flow back into the larger vessel and breaks the vacuum. The cups now fall off spontaneously and are lifted directly upward to avoid trauma to the cornea. The patient is permitted to remain at rest for an additional 15 minutes following which a drop of topical anesthesia is again instilled into each eye and the pressure measured. Normally, the intraocular pressure will have become elevated during the time the cups were applied but will return to presuction pressure level within 15 minutes after this has been removed.

Principle. The negative pressure applied through the polyethylene tubes to the contact glasses exerts a pressure greater than that inside the eye and thus compresses the episcleral vessels terminating the flow of aqueous out of the eye. As a result, the intraocular pressure continues to rise since secretion of aqueous humor continues during the 15 minutes the pressure remains in effect. In the glaucomatous eye, the return to presuction tension levels is delayed beyond the 15 minutes required in the normal. The rate of this fall of pressure during the decay time is an index of the resistance to the flow of aqueous out of the eye and serves as an aid in the diagnosis of early glaucoma.

Contraindications. Whereas tonography can be employed on any type of glaucoma in a cooperative patient, the perilimbal suction cup test should only be employed in the open-angle variety of glaucoma which comprise about 90 per cent of all glaucomas. The performance of this test in a narrow or angle-closure type of glaucoma could precipitate an acute attack of glaucoma with all its complications in a patient who has had no previous attack. It is, therefore, important that all patients referred to our Center have gonioscopy performed prior to the test. This test will be done at this Center in all patients who do not present evidence of these findings, prior to application of the perilimbal suction cups.

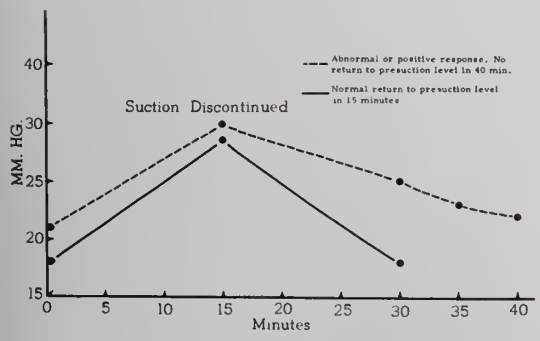

Fig. 3—Graphic representation of pressure decay in the normal and glaucomatous eye.

TABLE 1—*Pressure Decay Measurement in a Normal and Abnormal Eye*

	Presuction	Post Suction Immediate	15 Minutes Post-suction	20 Minutes Post-suction	25 Minutes Post-suction
Normal	18	29	18		
Glaucoma	21	30	25	25	22

The pressure is found increased after the suction cups are removed but in the normal will return to presuction test level within 15 minutes after removal of the suction cups.

A very nervous labile type of patient may best be served by postponing the test until a state of relaxation can be noted. A recent incident of failure to perform this test was probably due to a neglect of this factor in a 40-year-old female who was quite apprehensive about this test and who, despite assurance on our part, presented a very rapid pulse. An additional error on our part was probably the presence of residents with whom she was unacquainted. In our enthusiasm to demonstrate the procedure the above warnings were neglected with the result that at the moment the cups were applied and the vacuum established the patient became hysterical. The test was immediately terminated, but this entire incident might have been avoided had the operator been more perceptive. This represents the only case to date that could not be completed.

Results. Table 1 presents the pressure decay measurements in a normal and glaucomatous eye. Figure 3 presents these same eyes graphically to show the decay time required in the normal and abnormal eye. In the normal eye the presuction tension level is attained 15 minutes after suction is discontinued, whereas in the glaucoma patient the decay time is prolonged. This latter type of curve or graph can be demonstrated as well in the inadequately controlled patient and serves as a check on the tonogram that

presents a falling outflow value or increased Po/C value as described in 1961.[4] The presence of a prolonged decay time is consistent with a diagnosis of serious outflow impediment; and if repeatable, helps make the diagnosis of early or preclinical glaucoma at a time when few or no other signs may be demonstrable.

Conclusions. Our experience with this new method of investigation confirms previous findings and leads us to believe that this method of testing is of decided value in those that would not normally be considered good candidates for the tonographic means of evaluation. The method also lends itself as a means of testing outflow facilities on those that are good candidates for tonography and in this manner can act as a confirmatory check of the former. We are now employing this test primarily in those patients who present equivocal findings during our battery of tests employed in an attempt to diagnose the presence or absence of glaucoma. It is in these marginal cases that the ingenuity and diagnostic acumen of the physician is truly tested for one is most averse to placing the stamp of glaucoma on this type of patient. Once this is done we are creating an ocular cripple, particularly in the patient who has no symptoms, no visual embarrassment and no clinical evidence of ocular damage. On the other hand, it is most difficult to stand by and take the attitude that one should wait until evidence of optic nerve damage has occurred before therapy be instituted.

Therapy is recommended in those patients who present repeatable tests that show evidence of sufficient outflow deficiency as manifested by tonography and/or perilimbal suction cup testing. This in the patient who presents no other positive findings indicates that we are treating the patient who presents the earliest of changes that could not be demonstrated prior to tonography or the perilimbal suction cup test. Occasionally one finds a patient who presents equivocal findings in the tonogram and continues to do so when the perilimbal suction cup test is performed. In this group of patients we continue to repeat the tests at suitable intervals to ascertain any pertinent changes that may eventuate. A doubtful case that continues to present equivocal findings will be retested at yearly intervals.

While instrumental errors do not exist in this new procedure, the technical aspects do leave sources for error. We assume that complete occlusion of drainage vessels occurs when negative pressure of 50 mm. Hg. is applied, but know that our results will occasionally present the patient whose pressure immediately after suction is lower than the presuction reading. This has been reported by Langham[6] and is confirmed in our findings and indicates inadequate occlusion of the perilimbal outflow vessels by the cup. Slight displacement of the cup can readily leave drainage vessels open, causing the fall in intraocular pressure. The effects of rising intraocular pressure on occlusion status and secretion rate also will continue to require further studies. Despite these and other sources of error inherent in the patient or operator, the perilimbal suction cup test is proving itself a practical and fairly precise method of measuring the facility of aqueous outfllow, especially when used in conjunction with tonography. This does not mean that this method will supplant any of our present methods of investigation, for it merely places another tool in the hands of the ophthalmologist. Any method of examination that will give essential information and aid in the earlier diagnosis of so insidious and blinding disorder as glaucoma should be employed along with our present known methods to prevent the irreversible blindness that can and does occur. The method of examination presented here is inexpensive, simple to build and operate, and affords a considerable research potential.

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REFERENCES

1. Rosengren, B.: Rise in ocular tension produced by circumlimbal pressure on sclera, Tr. Ophth. Soc. U. Kingdom 76:65, 1956.
2. Galin, Miles A., Baras, I. and McLean, John M.: Uses of perilimbal suction cup in ophthalmology. Presented at the Sixty-Sixth Annual Session of the American Academy of Ophthalmology and Otolaryngology, October 8–13, 1961, Chicago, Ill. (An apparatus which will become commercially available was demonstrated by Doctor Galin and Associates at the 1962 Meeting of the American Academy of Ophthalmology and Otolaryngology.)
3. Grant, W. M.: Tonographic method for measuring facility and rate of aqueous flow in human eyes. Arch. Ophth. 44:204–214 (Aug) 1950.
4. Garner, L. L.: Tonography—an advance in diagnosis, prognosis and treatment of glaucoma, Wisconsin Med. J. 60:127–134 (Feb) 1961.
5. Schimek, R. A.: Ochsner Clinic, New Orleans 15, La.
6. Langham, M. E.: Evaluation of pressure cup technique for measurement of aqueous humor formation. Invest. Ophth. 1:484–492 (Aug) 1962.

Levels of Consciousness in Acute Head Injuries

By BAHIJ S. SALIBI, M. D., Marshfield, Wisconsin

■ IN THE management of acute head injuries, it is generally agreed that one of the most important factors, if not the most important factor, upon which the decision rests between surgical intervention and conservative management is the *change* in the patient's state of consciousness. With a progressive deterioration in the patient's level of consciousness over a period of time, a hematoma or possibly some other expanding intracranial lesion is ordinarily suspected. Such a patient usually demands a more radical therapeutic management than one whose state of consciousness is stable or improving.

It is easy to ascertain which patient is alert and which is deeply comatose. However, in the change from alertness to deep coma, the patient's state of consciousness will often pass gradually through a number of identifiable stages or levels which require careful observation. The early detection of these changes may significantly improve the patient's prognosis by calling for immediate surgical intervention before irreparable damage has occurred. The following outline is a preliminary attempt to define these levels or stages, derived from personal clinical observations over a number of years in civilian and military neurosurgical practice.

The commonly observed levels of consciousness, in their descending order of deterioration, are:

1. Alertness vs. lethargy: This is the earliest stage, as a rule, and is not always easy to detect. The patient should be examined at frequent intervals to determine whether he is becoming progressively more lethargic or drowsy; that is, more difficult to arouse and less able to give intelligent responses to questioning.

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2. Ability vs. inability to cooperate: As lethargy increases, a stage is eventually reached in which the patient is too lethargic to cooperate; e.g., in feeding and dressing himself. This is unlike the uncooperative attitude of an acute alcoholic who has lost some of his inhibitions and who will often become uncooperative before rather than after his lethargic stage. Unfortunately, head injuries are so often associated with alcoholic intoxication, that the reliability of this level as a clinical sign is decreased. Also noteworthy is the fact that there is often a certain degree of overlap between this level and the next, namely between the loss of ability to cooperate and the broad stage of progressive disorientation.

3. Orientation vs. disorientation: At this stage, consciousness appears to deteriorate in a fairly regular pattern. Four separate substages through which the patient passes, can usually be recognized. First, the patient becomes *disoriented in relation to time*, although he may still know where he is and recognizes his surroundings. The second substage is *disorientation in relation to place.* This indicates a deeper clouding of consciousness than does disorientation to time. Disorientation to time implies merely a loss of recent memory, whereas disorientation to place implies that the patient has also lost some ability to draw conclusions as to where he is from the appearance of his surroundings. The third substage is *disorientation in relation to person*, namely when the individual fails to recognize his associates or members of his family. Personal attachments, as a rule, are more deeply ingrained in one's consciousness than are his surroundings. Hence, disorientation to person, when it occurs, indicates a more serious impairment of consciousness than the two previous substages. Finally, the fourth substage is *disorientation to one's own person*, namely when the person fails to respond to his name. Apparently, there is a natural tendency for

an individual to recognize himself longer than he can recognize any other person, as he is progressively losing consciousness.

4. Ability vs. inability to obey simple commands: The ability to obey simple commands, such as "squeeze my hand" and "open your eyes," is usually not lost until after the patient has already failed to respond to his name. There is a possible logical explanation for this in that when the patient's name is called, the mere calling of his name implies a command for him to answer. Therefore, if he answers, it means that he at the same time is obeying the examiner's implied command. The response to simple commands appears to be the lowest level involving verbal communication between the examiner and the patient. Beyond this stage, the patient must be tested by physical rather than verbal stimuli.

5. Response to painful stimuli: This also appears to be altered or lost in a stepwise pattern. First, the response is *purposeful,* then it becomes *purposeless,* and then *absent.* An individual with a *purposeful response to pain* will try to remove the offending stimulus or pull away from it. On the other hand, a patient who responds merely by moving his leg irrelevantly, or by hyperventilating, is said to have a *purposeless response to pain.* Such an individual is naturally more deeply comatose than the one who responds purposefully, and less comatose than the one who fails to respond to pain at all. An individual with *absent response to pain* is in very deep coma. The response to pain is usually elicited by supraorbital pressure.

6. Corneal and gag reflexes: These are usually, but not always, the last to go. Thus, to be safe, an individual should be placed in the semi-prone position, or the so-called "coma position," well before the gag reflex has disappeared. In this position, the patient is placed on his side with the lower shoulder placed posteriorly, the head slightly extended and the mouth pointing definitely downward. This will enable the patient's tongue and secretions to fall forward and out, rather than to drop backward into his pharynx where they would obstruct respirations. Hence, the important dictum: *"never leave a comatose patient on his back."* I have personally known three tragic occasions in which unnecessary death occurred from failure to observe this dictum.

7. Vital signs—Blood pressure, pulse, respirations and temperature: These may begin to change well before the patient has become comatose. They are placed last in the scale, however, because they can still be followed even after complete coma has supervened. With uncomplicated rise in intracranial pressure, the systolic blood pressure usually rises and the pulse slows down. Also, the respirations may become deep and slow, later becoming irregular, stertorous or Cheyne-Stokes in type. Finally, a sharp rise in temperature frequently foretells extreme danger.

The vital signs are often difficult to interpret because of interference from other complicating factors such as atelectasis from aspirated vomitus. The latter complication would tend to raise the pulse rate, lower the blood pressure, and produce rapid shallow respirations, thus tending to neutralize the effect of increased intracranial pressure on these vital signs. In such a patient, the vital signs may be normal, despite an expanding intracranial hematoma which calls for immediate evacuation. These considerations must always be borne in mind in the evaluation of any serious head injury.

On the other hand, and especially in the absence of pulmonary complications, a significant rise in blood pressure and/or slowing in pulse may be followed by death in a relatively short period of time, even if the patient's level of consciousness is still seemingly good. Prompt treatment or arteriographic investigation should be instituted in such cases regardless of the level of consciousness.

Finally, a plea should be made to describe the state of consciousness by reporting in objective terms how the patient responds, rather than in general terms such as "listless," "semi-comatose," or "out in left field." Such terms are interpreted differently by different observers, and can therefore be misleading. On the other hand, a statement such as "fails to obey simple commands, but has a purposeful response to pain," or perhaps "disoriented to time and place but oriented to person," describes the patient's condition more accurately, and allows a more prompt detection of any deterioration in the patient's state of consciousness on subsequent examination.

The accurate description of a patient's exact level of consciousness at various times becomes especially important during prolonged transportation of the acutely injured patient who may have to make several stops on his way to the neurosurgeon, as sometimes necessarily occurs in the military. In such instances, it is desirable to have the patient examined at each stop by the local physician at that station, and have the exact level of consciousness and the time at which it is checked both recorded in the patient's accompanying chart. In this way, if the patient has undergone the tell-tale "lucid interval" of an intracranial hematoma while in transit, and becomes comatose again on reaching the neurosurgeon, the latter will have a clear record of the occurrence of such a lucid interval and will institute immediate surgical intervention without the need for an additional observation period before surgery.

650 South Central Avenue.

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin.

1. **Interprofessional Code**
   An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

2. **Guide to The Service Corporation Law**
   A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

3. **Code of Necropsy Procedure**
   A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

4. **Hearing Conservation Programs for Wisconsin Industries**
   Some recommended standards and principles for providing a hearing conservation program in industry.

5. **Occupational Health, A Guide for Medical and Nursing Personnel**
   General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.

6. **Find Your Future in the Health Field**
   A career guide (the health careers brochure).

7. **Guide to Immunization Planning**
   An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

8. **A Guide for Physicians, Hospitals and News Media**
   A discussion of news relationships between physicians, hospitals, newspapers and radio and television stations. It includes information concerning patients, physicians and county medical society news, health educational efforts and advice on the use of the title "Doctor."

9. **Inspection of Medical Records**
   An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

10. **School Health Examinations**
    A guide for physicians and school authorities in establishing a program of school health examinations.

11. **School Vision Screening Program**
    An outline to facilitate the development of a program to detect significant visual defects among school children.

12. **First Aid Chart**

13. **Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959**
    Relating to fee splitting between physicians and others.

14. **The Doctor's Role in Adoptions**
    A reprint of three Wisconsin Medical Journal articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

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Treatment of Poisoning Due to Cyanide

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■ CYANIDE, whether inhaled as hydrogen cyanide or administered as a salt, is a poison which can kill quickly and should be treated with haste. Cyanide inhibits a large variety of hematin enzymes at concentrations as low as 10^{-6} and 10^{-7} M. The predominant effect of cyanide appears to be on the respiratory enzyme, cytochrome oxidase, which is concerned with the transfer of molecular oxygen by way of the cytochromes for cellular oxidation of various substrates. Concentrations of cyanide as low as 3×10^{-8} M have been shown to completely inhibit cytochrome oxidase *in vitro* and lethal doses of cyanide have been reported to produce *in vivo* inhibition of this respiratory enzyme. It should be emphasized that in cyanide poisoning, oxygen transport by the blood is usually adequate, but the cellular utilization of oxygen is depressed due to enzymatic inhibition. This histotoxic anoxia produced by cyanide would cause a shift in tissue metabolic processes from aerobic to anerobic metabolism. This, of course, would result in such changes as an increased utilization of glycogen and high energy phosphorus containing compounds, i.e., creatine phosphate and adenosine polyphosphates, and an accumulation in tissues of lactic acid and inorganic phosphate.

The fatal dose of cyanide by a variety of routes of administration, i.e., inhalation, cutaneous, oral, subcutaneous and intravenous, indicates that the absorption of approximately 0.5 to 1.5 mg. per kg. of sodium cyanide into the tissues is lethal. The signs and symptoms produced in an individual who is subjected to an approximately lethal dose of cyanide are: collapse, convulsions and depressed respiration which may lead to death or after a period of a few hours to recovery. Most of these individuals recover without any apparent neurological damage. However, a few cases of various neurological and psychological disturbances have been reported to persist for several weeks with, again, either recovery or death. It is of interest to note that in cases of cyanide intoxication, demyelinating changes in the central nervous system have been described and that these pathological changes may underlie the neurological and psychic effects observed.

Treatment. Since the predominant toxic effect of cyanide is attributed to the inhibition of cellular oxidation by its combination with the cytochromes, the principal aim of therapy, other than the direct removal of the poison, is to select a combination of drugs which would competitively react with cyanide before or after it has combined with the hematin enzymes and ultimately to convert cyanide to a less toxic substance which can be excreted from the body.

The first of these drugs employed in antagonizing cyanide intoxication is usually a nitrite derivative. These compounds exert their effect by the conversion of hemoglobin to methemoglobin. The latter compound combines with the cyanide ion to form cyanmethemoglobin and thus competes with cytochrome oxidase for the toxic anion. It should be pointed out that methemoglobin does not have a higher affinity for cyanide than cytochrome oxidase. The exchange reaction is attributed mainly to the high concentration of methemoglobin which can be attained in the circulation.

The second compound employed in the therapy of cyanide poisoning is usually a

Continued on page 381

SMALLPOX VACCINATION IN HOSPITALS

WITHIN the last three years, 129 cases of smallpox, with 33 fatalities, occurred in Western European countries. Sixty-five cases were hospital-acquired. Of these, 25 died from the illness including two physicians and two nurses.

In the United States, no indigenous cases occurred in the last 14 years.[1] At the end of World War II, outbreaks of malignant smallpox occurred along the Pacific coast, resulting from transmission by returnees from Korea. In Seattle, 40 cases, with eight deaths, occurred largely among hospital staffs and patients. The notorious New York outbreak in 1947 was limited to 12 cases, mostly among the staff and patients of hospitals. The last smallpox outbreak occurred in this country in 1949 among migrant laborers in Hidalgo, Texas. A total of six cases was recognized.

The smallpox outbreaks in Western Europe in 1961–1963 present many interesting clinical, epidemiological, and administrative problems. Only the importance of hospitals in the epidemiology of this disease will be highlighted in this report.

In the Dusseldorf outbreak the index case was diagnosed as "scarlet fever;" in Monschau Kries as "chickenpox;" in Bradford as "malaria" (because the patient had a positive blood smear), and in the other English cases the diagnosis was promptly made. In Sweden the index case had a mild fever and rash, and had not been seen by a physician. In Cardiff the first generation case was a pregnant woman who miscarried at home and was hospitalized for retained placenta. She died while being prepared for surgery. The anesthetic equipment used for resusscitation was used subsequently on another patient and this second patient developed smallpox, as well as the obstetrician who attended the autopsy of the pregnancy case. Among contacts at the funeral of the first generation case, new cases of smallpox developed. It is noteworthy that the prompt diagnosis and isolation of the index cases in West Bronwich, London, and Birmingham resulted only in the development of three secondary cases.

In Germany and England the hospital personnel had inadequate vaccination coverage. Infected hospital employees spread the disease to patients in these outbreaks. In Sweden the hospital personnel were very well vaccinated and not only the number of cases among hospital employees was low, but also patients were not as severely exposed as in the outbreaks in the other two countries. In the Swedish outbreaks, one of the nurses developed fever, headache and nausea, but no rash. She had been vaccinated one year previously; however, there is no record on her "take." The second nurse in this outbreak had similar symptoms. She was vaccinated in 1950. Both cases had a high hemagglutination inhibition antibody titer (HIA) on which the diagnosis was based. The other hospital employee in Sweden was a gardener who was handling the laundry of a smallpox patient, and was at that time diagnosed as "chickenpox." This hospital employee was never vaccinated.

Fatalities reported in England and Sweden occurred among persons vaccinated 15 years or longer, before exposure. The occurrence of cases without rash, (but diagnosed by a high hemagglutination inhibition antibody titer among the vac-

TABLE 1—*Smallpox Epidemics in Germany (1961–1962), Great Britain (1961–1962), and Sweden (1963) Summary of Outbreaks*

Place of Occurrence	THE IMPORTED CASE			INDIGENOUS CASES						
				Secondary Cases by Generation						
	Source	Date of Arrival	Date of Onset	1st	2nd	3rd	4th	5th	Total	Deaths
Germany										
Dusseldorf	Liberia	12-12-61	12-13-61	2	1	1			5	2
Monschau Kries	India	1-23-62	2-8-62	4	15	12			32	1
England										
Bradford	Pakistan	12-16-61	12-23-61	10	3				14	6
West Bronwich	Pakistan	12-19-61	12-21-61	1					2	0
London	Pakistan	12-25-61	12-24-61	2					3	1
Birmingham	Pakistan	1-4-62	1-8-62						1	0
Wales										
Cardiff	Pakistan	1-11-62	1-13-62	1	7	19	1	20	49	19
Sweden										
Stockholm	Indonesia	3-24-63	4-16-63	4	10	6	2		23	4
TOTALS									129	33

Source: See references.

TABLE 2—*Smallpox Epidemics in Germany (1961–1962), England (1961–1962), and Sweden (1963) Cases Acquiring Disease By Hospital Contact*[2]

Profession or Status	Germany		England		Sweden		Totals	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Physicians	3		3	2			6	2
Nurses	3	2	1		2*		6	2
Other hospital employees	4		1	1	1†		6	1
Visitors			2	2			2	2
Patients in hospital	9	1	33	16	3	1	45	18
Total hospital cases	19	3	40	21	6	1	65	25
All secondary cases in the outbreaks	36	3	62	26	20	3	118	32
% of hospital cases of total secondary cases	52.8%	100%	64.5%	80.8%	30.0%	33.3%	55.1%	78.1%

*Additional three nurses became infected in home nursing service.
†Additional case in a mortician preparing a body of a case.
Source: See references.

cinated persons), and the mild cases with rash but not seeking medical attendance greatly contributed to the spread of this illness. The last case reported in Sweden is of interest: An 85-year old woman developed fever and skin rash, and was diagnosed as "smallpox" on June 2, 1963. She lived with her daughter, a mortician who prepared the body of one of the smallpox victims on April 26, 1963. The mortician was quarantined and released 16 days later, having no symptoms or signs of illness. The total time between her exposure to the body and the onset of the disease in her mother was 32 days, consistent with two incubation periods of smallpox. Neither the mother nor the daughter had been vaccinated since childhood. The daughter had a high HIA titer on June 6, 1963, suggesting a recent infection.

The following general observations can be made about smallpox epidemics in Western countries:

1. The smallpox outbreaks which did occur were imported from Asia and Africa. The potential of importation of this disease into the United States from South America is a real threat.
2. Severe smallpox cases and fatalities occur among the unvaccinated or inadequately vaccinated persons.
3. Mild, atypical cases or asymptomatic carriers can occur among persons vaccinated three years or longer before exposure. These unrecognized cases may initiate an epidemic, and the transfer of disease is through close contact with the general population and hospitals.
4. Hospitals must be considered as potential major sources of "spread" in countries where disease is endemic or almost unknown. Secondary or infectious cases among physicians, nurses, aides, and other hospital employees transfer the disease to other hospitalized patients before the true diagnosis of the index case is made.
5. The Swedish outbreak demonstrated the effectiveness of vaccination of the hospital personnel and the consequences of missing vaccinations. (The appearance of a mild case of smallpox in a nurse that had a recent vaccination is not explained).

GENERAL RECOMMENDATIONS. The Public Health Service, in 1960, developed a brochure, "Procedures of Prevention or Containment of an Outbreak of Smallpox."[1] This document recommends three lines of defense:

1. Enforcement of international regulations with regard to vaccination requirements, holding all suspicious cases, and notification of all health agencies concerning areas of the world where smallpox cases occurred.
2. The maintenance of base-line level immunity in infants and prior to school entrance.
3. Maintenance of a high level of immunity among the "high risk" groups, such as persons working in ports, transportation personnel, and

TABLE 3—*Epidemic of Smallpox, Great Britain (1962) Vaccination Status of "Hospital Acquired" Cases*[2]

Vaccination Status	Fatalities No.	Survivors No.	Total No.	Death Ratio Per 100 Cases
Vaccinated within 7 years	0	0	0	0
Vaccinated within 15 years	0	1	1	0
Vaccinated more than 15 years ago	5	5	10	50%
Doubtful if ever vaccinated	3	1	4	75%
Never known to be vaccinated	13	12	25	52%
TOTAL	21	19	40	52.2%

Source: See references.

TABLE 4—*Epidemic Smallpox in Sweden, 1963 Vaccination Status of Indigenous Cases**[2]

Vaccination Status	Cases	Rash	No Rash	Deaths
7 years or less	2		2	
8–14 years	3	1	2	
15–24 years	2	1		
25–50 years	4	3		
More than 50 years	6	5	1	2
Never	3	3		1
TOTAL	20	13	5	3

*No information is available about additional two new cases and one death reported in June, 1963.
Source: See references.

especially individuals who have contact with patients in the hospital setting.

RECOMMENDATIONS TO BE FOLLOWED IN WISCONSIN. The opening of the St. Lawrence seaway made the communities situated along the Great Lakes a part of the international shipping trade. The great number of tourists returning from overseas and the number of foreign students coming to our country create in every Wisconsin community a potential for the introduction of smallpox. The Public Health Service recommendations are re-emphasized for Wisconsin:

1. *Vaccinate every infant in Wisconsin.* The complications of vaccinations are mild and occur less frequently in the age under one year. Morbidity from revaccination is mild if no complications occurred in the primary vaccination.
2. *Revaccinate each child before he enters school.* This is the first group exposure of these children. Revaccinate if feasible during the period of school attendance. If this procedure is followed, the majority of children will be protected, and if mass vaccination is needed in an area, the school group will be protected in advance.
3. *Vaccinate all members of the "high risk" group outlined above.*
4. *Every person having contact with hospital patients, cadavers, and with fomites of hospital patients shall be vaccinated prior to employment.* The Public Health Service recommends revaccination of these persons every three years.
5. The Committee on Infections in every hospital should establish an administrative procedure to ensure that every one of the full-time employees, part-time employees, and members of the visiting staff has the proper smallpox vaccination needed for his own protection and the protection of the patients in the hospital.

—JOSEF PREIZLER, M.D., F.A.C.P.M., director of the Bureau of Communicable Diseases, Wisconsin State Board of Health, Madison.

ADDENDUM. Following the writing of this article, the following information was received: Smallpox outbreak in Poland with 110 cases and 7 deaths, single cases in Hungary and Switzerland.—J.P.

REFERENCES

1. Public Health Service: Procedures for prevention or containment of an outbreak of smallpox, Washington, D. C., March, 1961.
2. The tabulations were compiled from the weekly morbidity and mortality reports—Public Health Service, Communicable Disease Center, Atlanta, Ga., Vol. 12, no. 20–28, and personal communication from J. D. Millar, M.D., Chief, Epidemic Intelligence Service, P.H.S., C.D.C., Atlanta, Ga.

COMMENTS ON TREATMENT *Continued from page 378*

sulfur donor. Once cyanmethemoglobin is formed, a sulfur donor, e.g., certain thiosulfates and thiosulfonates, is administered in order to convert to thiocyanate, the cyanide which is released by the dissociation of cyanmethemoglobin. This detoxication of cyanide is carried out in the body in the presence of the enzyme, rhodanese. More recently it has been reported that the administration of crystalline rhodanese directly into the circulation can markedly enhance the antagonism of cyanide intoxication.

The mechanism of cyanide intoxication and its antagonism can best be summarized by the following series of reactions:

Ferricytochrome oxidase + $CN^- \rightleftharpoons$ Ferricytochrome oxidase cyanide

Hemoglobin + $NO_2^- \rightleftharpoons$ Methemoglobin

Methemoglobin + $CN^- \rightleftharpoons$ Cyanmethemoglobin

$$CN^- + S_2O_3^{=} \longrightarrow SCN^- + SO_3^{=}$$

In regard to a specific course of treatment of cyanide poisoning,[1] 0.3 Gm. of sodium nitrite is dissolved in 10 ml. of water, and 12.5 Gm. of sodium thiosulfate is dissolved in 25 ml. of water. While these solutions are being readied for intravenous administration, ampules of amyl nitrite should be crushed and administered by inhalation, instituting artificial respiration to the patient if necessary. Up to eight ampules may be administered successively. This should be followed by the administration of a solution of sodium nitrite over a period of 3 or 4 minutes and subsequently by the administration of a solution of sodium thiosulfate over a period of about 10 minutes. Oxygen inhalation and other supportive measures such as blood transfusions should be instituted if the patient is breathing poorly.

The use of newer agents in cyanide poisoning, such as *p*-aminoprophenone as a methemoglobin former, the thiosulfonates as sulfur donors and the crystalline enzyme, rhodanese, should await further studies to determine their safety and efficacy.

REFERENCES

1. Chen, K. K. and Rose, C. L.: Nitrite and thiosulfate therapy in cyanide poisoning, J.A.M.A., *149*:113–119 (May 10) 1952.

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CLINICOPATHOLOGIC CONFERENCE

P
C

Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: ROBERT L. KASCHT, M. D.

Waukesha, Wisconsin

Case Presentation.* The patient was first admitted to the hospital when she was five years old because of fever, loss of appetite and purulent drainage from the gums of approximately two to three weeks duration. Physical examination revealed a child who was small for her age and who appeared chronically ill. Her teeth were blackened and broken at the gum line. There was purulent discharge from multiple alveolar abscesses. The cervical nodes were enlarged. Rales were present in both lung bases. Heart rate and rhythm were normal; no murmurs were heard. The abdomen was not remarkable. Her legs were bowed. The child walked with a pigeon-toed gait.

Laboratory returns showed a hemoglobin level of 88%, hematocrit reading 43%, white blood cell count 5,900 per cu. mm. with a differential of 56 segmented neutrophils, 4 stab forms, 35 lymphocytes, and 5 monocytes. Nonprotein nitrogen was 25 mg. per 100 ml. Urinalysis: straw; cloudy; 1.010; alkaline; albumin 3 +; sugar, trace; acetone, trace.

X-ray films of the paranasal sinuses revealed a uniform haziness of both maxillary antra which was interpreted as sinusitis. The chest film was negative.

Past history revealed that at approximately two years of age (August 1954) the child was taken to an orthopedist because of delay in walking. X-ray films taken at that time were reported as showing rarefaction of the bones of the wrists. A diagnosis of active rickets was made. The laboratory data from hospitalization at that time included a urinalysis of 1 + protein, 1 + acetone, acid pH, trace of sugar, 1 to 3 red blood cells and 6 to 8 white blood cells per high-power field; sedimentation rate of 16 mm. per hour; serum calcium 10.3, and phosphorus 2.75 mg. per 100 ml.

In September 1958, the child was studied at the Shriners Hospital for Crippled Children. Extensive laboratory data was accumulated. Urinalysis revealed 4 + sugar and 4 + protein on repeated tests. The blood sugar was within normal limits. Blood urea nitrogen was 10, phosphorus 3.6, calcium 7.0 and 9.8 mg. per 100 ml. The calcium-phosphorus product was 22.3. Alkaline phosphatase was 11.4 units (normal 1.5 to 4.5 Bodansky units).

Urine creatinine was 1.14 Gm. and creatine 0.208 Gm. per 24 hours; blood carbon dioxide combining power was 42 vol.% and later 55; chlorides 592 mg. per 100 ml.; sodium 142 mEq./l.; total serum protein 5.7 Gm., with albumin 4.2 and globulin 1.5 Gm. per 100 ml.; 24-hour urine sugar 0.82 Gm. and 24-hour urine calcium 293 mg. Galactose tolerance was normal.

One month after this hospitalization, some of the studies were repeated. Serum calcium was 9.7 and phosphorus 2.3 mg. per 100 ml.; alkaline phosphatase 15.9 units.

Family history revealed the father to be diabetic. During hospitalization the infected tooth roots were removed under general anesthesia after a trial of one week on antibiotics was unsuccessful. The patient was discharged three days postoperatively.

In the interval between the first and second admissions to this hospital, the child had multiple bouts of tonsillar infection. She was admitted to the hospital for evaluation approximately two years after the first admission because the mother had noted that she was lethargic, slow reacting and did not play with children of her own age. The physical examination at this time was essentially negative except for the presence of markedly hypertrophied tonsils.

Laboratory studies showed a hemoglobin level of 11.5 Gm. per 100 ml.; hematocrit reading of 33.5%; white blood cell count 7,650 per cu. mm. with a differential of 50 segmented neutrophils, 2 stab forms, 39 lymphocytes, 6 monocytes, and 3 eosinophils. Urine was yellow; specific gravity 1.015; al-

* From Waukesha Memorial Hospital.

Fig. 1—Paper chromatagram of urine.

kaline; albumin 3+; sugar negative. A repeat urinalysis two days later revealed a trace of sugar. Occasional red blood cells and 10 to 15 white blood cells per high-power field were seen. There were also occasional granular casts. Blood urea nitrogen was 21 and serum chloride 629 mg. per 100 ml. (normal range 450 to 600). Carbon dioxide combining power was 50 vol.% (normal 55 to 70 vol.%). Total protein was 5.98 Gm. per 100 ml. with albumin 4.02 and globulin 1.96. Serum calcium was 9.35 and phosphorus 3.15 mg. per 100 ml. Alkaline phosphatase 17.9 King Armstrong units (normal less than 15).

During this hospitalization, paper chromatographic studies on the urine were performed and revealed increased aminoaciduria. The specific amino acids were not identified. The patient was placed on a low-salt regimen and discharged.

The third admission to the hospital occurred two and one-half years later, or approximately four and one-half years after the first admission. The patient had experienced a convulsion five days earlier. During this interval, she had been seen frequently by the attending physician. Reportedly, the child had experienced increasing weakness, lethargy, and decreased appetite. She also had some visual difficulty, although the nature of this was not explicitly stated.

Physical examination at that time described a nine-year-old child who appeared chronically ill. She was 3 feet 7½ inches tall. The heart rate was normal, but a Grade 1 systolic murmur was heard. Her blood pressure was 108/66. No other significant physical findings were recorded.

Laboratory studies showed blood urea nitrogen of 70, calcium 5.3, and phosphorus 6.5 mg. per 100 ml.; serum protein 6.40 Gm. per 100 ml. with albumin 4.72 and globulin 1.68. The hemoglobin level was 6.9 Gm. per 100 ml., hematocrit reading 19.5%, white blood cell count 4,300 per cu. mm. with a normal differential. Serum sodium was 138 and chlorides 104.8 mEq./l.; carbon dioxide combining power 20.5 mM./l.; uric acid 3.6 mg. per 100 ml.; 24-hour urine protein 1.7 Gm./l.; blood urea nitrogen 98 mg. per 100 ml. (prior to discharge). The urine was yellow, cloudy, 1.008, neutral, albumin 3+, sugar trace, acetone trace.

The patient was continued on a low-protein and low-salt regimen and was discharged.

The child was readmitted to the hospital following a second convulsive episode approximately two weeks later. She was given phenobarbital and was discharged the following day.

The last admission occurred approximately six months later. The child was unable to retain food or fluid and had been vomiting for approximately four days. She was very pale and lethargic. Her pulse was 110 per minute. No significant physical findings were observed other than those previously described.

On admission the hemoglobin level was less than 4 Gm. and the blood urea nitrogen 178 mg. per 100 ml. Supportive measures were given, but the patient's condition declined rapidly and she succumbed eight days after this admission. The blood urea nitrogen terminally was 232 mg. per 100 ml.

Clinical Discussion. *Dr. John R. Guy:* This was a chronically ill child who was small, had bowed legs, and had developed slowly. A diagnosis of rickets was made at the age of two years. She had had repeated infections, poor teeth with abscesses, and repeated tonsillitis. At the age of nine years, she was 43 inches tall. The lower limits of normal for this age is 46 inches. This chronically ill, physically retarded child went on to die a uremic death. If we look at the urine findings during her lifetime, we see that she con-

sistently showed protein starting at the age of two years. At the age of two years she had an acidic urine, and then it became alkaline, probably due to treatment. She also constantly showed glycosuria, although on one occasion her blood sugar was normal. The microscopic urinalysis showed a few red blood cells and white blood cells at the age of two years, and finally at the age of seven years, granular casts were noted. At that time, the urine showed an increased amount of amino acids.

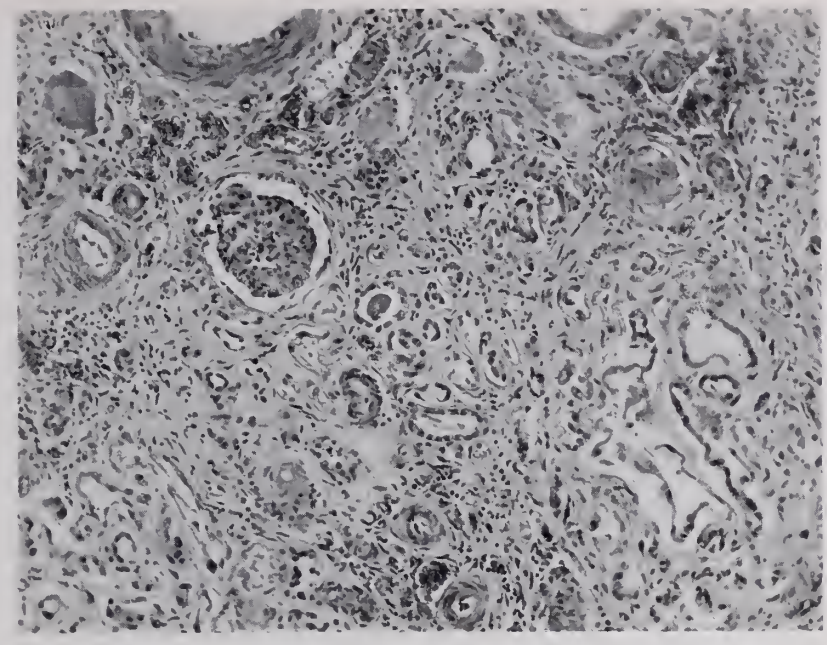

Fig. 2—Kidney showing glomerular scarring and decrease in parenchymal elements. (x420)

In reviewing the blood chemistries, we note that the blood urea nitrogen was normal at the beginning of her illness and rose to a terminal figure of 232 mg. per 100 ml. The carbon dioxide combining power was at the lower limits of normal or slightly acidic throughout the years. The phosphorus was always low, the calcium normal until the second last admission when the phosphorus was normal and the calcium was low. The alkaline phosphatase on all occasions was elevated.

Her serum proteins were low until the second last admission. In fact, on that admission, at the age of nine and one-half years, her blood chemistries were better than before, except for the blood urea nitrogen of 70 mg. per 100 ml. and a 3+ protein in the urine.

The diagnosis of rickets, which was made at the age of two years, would be substantiated by the findings of a high alkaline phosphatase, a low phosphorus, and normal calcium. The normal calcium-phosphorus product should be about 40 to 45. In this child, throughout the entire illness, we find that the figure was consistently below 35.

At the age of seven years, we note that an abnormal amount of amino acids was found in the urine. Paper chromatography was done, but no specific identification was made. This finding is important since we know that the amino acids are filtered by the glomerulus and reabsorbed by the tubule of the kidney. These amino acids are normal in the serum, and when they are filtered by the glomerulus, are reabsorbed for the most part by the tubules, usually in the range of 90 to 98% of the amount filtered. We also know that amino acids in the urine can be excreted in abnormal amount due to two things. One is an overflow, such as in phenylketonuria, hyperglycinuria, and maple syrup disease. These diseases have a high blood level of the amino acids which are filtered through the glomeruli in such a large amount that the renal tubules cannot reabsorb the entire amount filtered.

The other type of aminoaciduria is renal in origin.[1] Here even with a normal concentration of amino acids in the plasma and a normal filter load on the kidney, increased amounts of amino acids are excreted in the urine. Under normal conditions we would expect the renal tubules to reabsorb about 93% of all the amino acids filtered through the glomeruli.

In this latter group of renal aminoacidurias are such diseases as cystinosis, vitamin D deficient and resistant rickets, heavy metal intoxication, and multiple myeloma, to name a few.

In these the generalized aminoaciduria may be of no particular metabolic significance since the plasma level of the amino acid was not significantly lowered. It is of value in suggesting that further studies should be done to assess the full extent of the renal tubular defect.

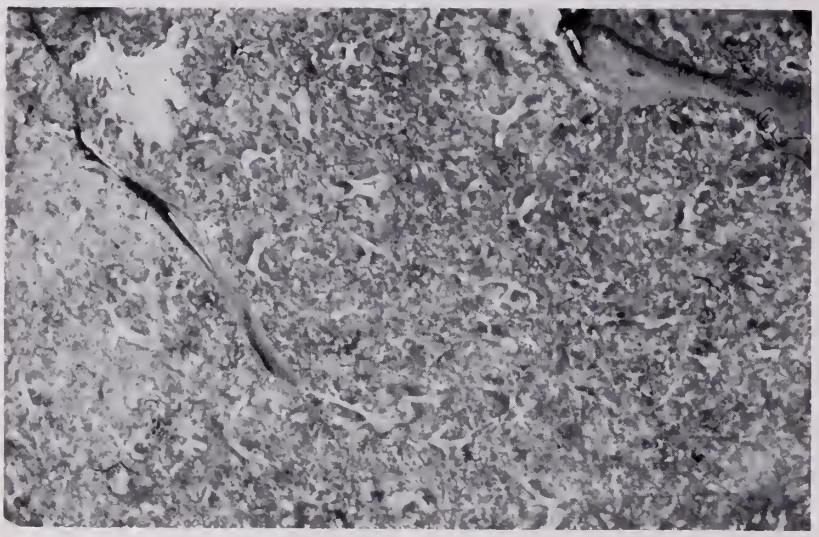

Fig. 3—Spleen; cut surface shawing granular quality due to deposits.

In our case, if we start at the age of two years, when an x-ray diagnosis of rickets was made, which I feel was further substantiated by the later laboratory findings, we must consider what type of rickets would conform with the findings.

We can divide rickets into four main groups, using the classification of Fraser and Salter.[2] Number one is the vitamin D deficient rickets; number two is chronic renal insufficiency; number three is renal tubular insufficiency; and number four is a miscellaneous group which includes only one condition, hypophosphatasia. The latter three groups do not respond to a normal amount of vitamin D.

If we consider the vitamin D deficient rickets first, we know that a dose of 2,000 to 3,000 IU should bring about evidence of healing within one to two months. Once the vitamin D deficiency has been ruled out, either by a history of an adequate intake or a therapeutic trial, we should next decide whether this is due primarily to glomerular dysfunction or tubular dysfunction. Usually determination of the blood urea and serum inorganic phosphorus will differentiate between glomerular or tubular dysfunction. Elevation of both indicates glomerular dysfunction, whereas a normal blood urea and a low phosphorus indicate a renal tubular defect. However, a secondary glomerular dysfunction may occur late in the case of rickets due to tubular dysfunction.

Because of this, further testing should be done which should include: (1) ophthalmoscopic examination of the cornea for cystine crystals, (2) routine urinalysis and urinary amino acid chromatography, (3) blood chemistry, including total serum calcium, inorganic phosphorus, alkaline phosphatase, blood urea, serum electrolytes, carbon dioxide content, and blood pH, and (4) x-ray films of wrists and knees.

In this case we can rule out vitamin D deficiency rickets, since this child had acidosis, glucose, and protein in the urine from the beginning, which would not be present in a vitamin D deficiency rickets. We would also assume that this child had been treated with fairly adequate doses of vitamin D after the discovery of rickets at the age of two years.

The second group is rickets of chronic renal insufficiency. In this group the evidence of chronic renal insufficiency usually antedates the onset of skeletal symptoms by about two years. In our case this was not true as the blood urea nitrogen was not elevated until the child was between seven and nine years of age. In this group also, aminoaciduria is absent because the glomerulus is damaged and does not filter the amino acids. This could be true late in a case of tubular dysfunction when glomerular damage may have developed and an aminoaciduria could have disappeared even though present earlier in the disease. This probably was true in our case, although no mention of the aminoaciduria was made during the last two admissions.

The third group is the rickets due to renal tubular deficiency. This group is divided into hypophosphataemic vitamin D refractory rickets of: (1) the simple type, (2) with aminoaciduria, (3) with aminoaciduria and acidosis, and (4) cystine storage disease. This group does not show evidence of glomerular failure; and, except for rickets, these patients may be in excellent health. There are several syndromes which present a confusing picture. Each group of men who discusses this subject has a different classifica-

tion. I feel the classification of Fraser and Salter[2] is by far the most logical. It has become evident in the last decade that derangement in the function of the tubule is present in all the syndromes that do not respond to the usual therapeutic dosages of vitamin D, that is, 2,000 to 5,000 IU daily. The usual pathogenetic mechanism of these rickets is phosphorus loss through the tubule. Large doses of vitamin D reduce the loss of phosphate. In the simple type, there usually is no aminoaciduria and no urinary protein or glucose loss. A balanced regimen with large doses of calciferol D_2, 40,000 to 50,000 IU daily, causes regression of deformities, but the children do not grow normally, and the majority remain below the third percentile in their growth.

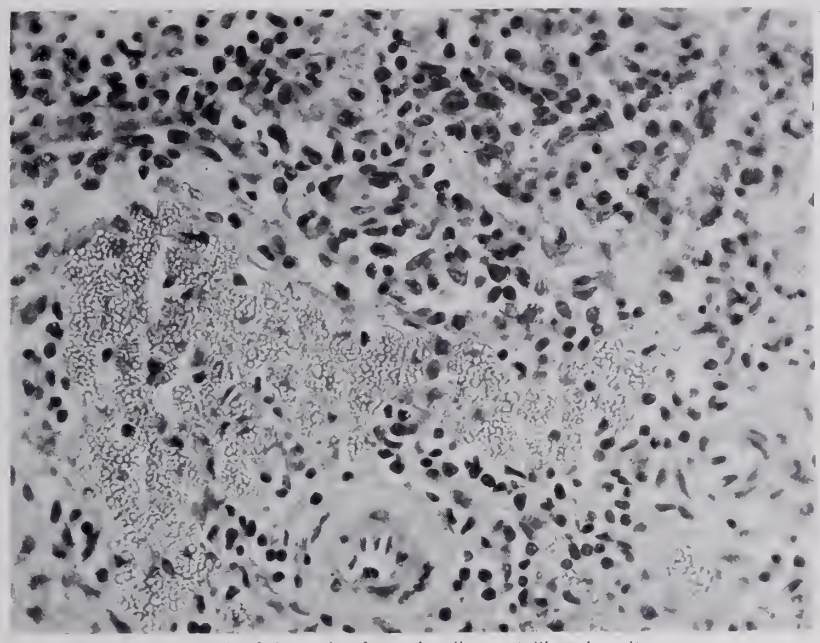

Fig. 4—Spleen showing refractile crystolline deposits assumed to be cystine. (x420)

In the second type, which is the hypophosphataemic vitamin D refractory rickets with aminoaciduria, the onset is earlier than the simple type. The muscular weakness is prominent, and because of this, the deformities are not as marked since the child is slower to walk and does not bear weight. The clinical findings are the same as in the simple type, but with an elevated alkaline phosphatase, decreased phosphorus, and normal or decreased calcium. However, there is glucose and protein in the urine and generalized aminoaciduria. Treatment with massive doses of vitamin D, 100,000 IU daily, may give apparently complete radiographic healing. Also, the biochemical changes, including aminoaciduria, disappear and there is significant improvement in the growth rate.

The last two classes, that of aminoaciduria with acidosis and cystine storage disease, are sometimes thought to be the same disease. Fraser and Salter[2] feel that they are separate, and that prognosis in cystine storage disease is much poorer. In these two groups, the tubular dysfunction affects the acid base regulation as well as giving all the findings seen in the group with aminoaciduria only. These last three groups, rickets with aminoaciduria, aminoaciduria with acidosis, and cystine storage disease, are also known as the Fanconi syndrome.[3]

In conclusion, I feel that we began with a case of hypophosphataemic vitamin D refractory rickets with aminoaciduria and probably acidosis, although the serum pH is not noted. The disease progressed to glomerular damage, producing uremia and the ultimate death of this child.

Radiological Discussion. *Dr. Robert C. Feulner*: Radiogrphically, there is no certain way of distinguishing vitamin D deficiency rickets from renal rickets. The roentgen examination is important only in evaluating the degree of healing. The absence of healing following vitamin D therapy may be an indication of refractory or renal rickets.

The x-ray examination of the knees may be particularly important as the rickets of renal origin sometimes makes its first radiographic appearance at the medial aspects of the femoral and tibial metaphyses of the knees.

Pathological Discussion. *Dr. Robert L. Kascht*: This case, which spans approximately 10 years, demonstrates the developing awareness of a new disease syndrome. When this child was first seen by an orthopedist for apparently retarded motor development, the x-ray films were interpreted

TABLE 1—*Summary of Pertinent Laboratory Data*

Normal		URINE					BLOOD							
							6–18.	4.5–5.15 mg./100 ml.	9–11 mg. 100 ml.	450–600 mg./100 ml. / 100–106 mEq./l.	1.5–4.5 B Under 15. KA	55–76 vol. % / 10–21. mM/l.	133–143 mEq./l.	6.5–7.5 Gm. / A. 4.5–5.5 G 1.7–3.0
Date	Age	Protein.	Acetone.	Ph.	Sugar.	Micro.	BUN	P	Ca	Cl	Alk. Phos.	CO_2	Na	Protein
Aug. 1954	2 yr.	+	+	Ac	Trace	1–3r bc 6–8 wbc	2.75	10.3						
	5 yr.	+++	Trace	Alk	Trace		NPN 25							
Sept. 1958	6 yr.	++++			++++		10	3.65	7.0 9.8	592	11.4 B	42 55	142	5.7 (4.2–1.5)
Oct. 1958								2.3	9.7		15.9			
	7 yr. Chromatography	+++		Alk	Trace	Occ. rbc 16–15 wbc granular casts	21	3.15	9.3		17.9 KA	50	629	5.9 (4–1.96)
	9½ yr.	+++	Trace		Trace		70 98	6.5	5.3	104 mEq.		20.5 mEq.		6.4 (4.7–1.68)
	10 yr.						178 233							

as demonstrating rickets, and the child was treated accordingly for a brief period of time. It was recognized that this was resistant rickets which failed to respond to vitamin D therapy.

The child was studied intensively at the Shriners Hospital for Crippled Children in 1958, and at that time the diagnosis of renal Fanconi syndrome with secondary resistant rickets was made. In 1959 amino acid chromatography was performed locally, and an excess number of amino acids was demonstrated in the urine. This is the first case of this disease studied in our hospital and demonstrates our increasing awareness of the syndrome which had been well known under a number of names in the European literature at least 20 years earlier. The classification of rickets with particular emphasis on the renal forms provided by Fraser and Salter[2] is particularly usable and simple. It is an objective clinical classification and does not bog down in the issue of the etiology of this syndrome. The principal theories proposed to explain the varied manifestations of this syndrome are (1) a general defect in amino acid metabolism, (2) a specific defect in renal tubular reabsorption, and (3) a defect particularly in the metabolism of cystine with consequent deposition of crystals which induces an inflammatory and degenerative change of the various organs, particularly the kidneys and to which the renal functional impairment is secondary.

The autopsy examination of this patient demonstrated nothing remarkable grossly. The microscopic features of interest were limited to the spleen and kidneys.

Inasmuch as the chemical alterations are those attributable to tubular dysfunction, it would be expected that the histologic changes should similarly reflect tubular damage primarily. However, in the section of kidneys in this case there was no specific tubular lesion. Predominantly, the glomeruli showed changes which were consistent with glomerulonephritis and there was a reduction in the number of nephrons. This would correlate well with the increasing azotemia. It was suggested in the discussion that because of the diminished filtration in the later stages of such cases there may not be the aminoaciduria which was noted earlier when the glomeruli were functioning more adequately. Unfortunately, we did not have a urine chromatogram for the last admission.

Other reports have described a "swan neck" deformity of the nephrons. Some reporters have not observed or confirmed this. In our sections nothing to suggest this configuration was seen. No crystals were recognized in the kidney. Therefore, the damage to the kidney parenchyma could not be ascribed to crystalline deposition. There was abundant refractile material deposited in the spleen. There was no inflammatory or degenerative reaction associated with these de-

TABLE 2—*Usual Biochemical Findings in the Various Types of Rickets*

Type	Type of Rickets	BLOOD CHEMISTRY					URINE FINDINGS			Tissue Cystine
		Calcium	Phosphorus	Alk. phosphatase	Urea	Acidosis	Glucose	Protein	Abnormal amino acids	
I	Vitamin D. deficiency rickets	N or ↓	↓	↑	N	0	0	0	+	
II	Osteodystrophy due to chronic renal insufficiency (Pannephritic osteodystrophy)	↓ or N	↑	↑	↑	+	0	+	0	0
III	Rickets due to renal tubular insufficiency:									
	A.									
	1. Hypophosphataemic vitamin D-refractory rickets of the simple type	N	↓	↑	N	0	0 (rarely +)	0	0	0
	2. Hypophosphataemic vitamin D-refractory rickets with aminoaciduria	N or ↓	↓	↑	N	0	+	0 or +	++	0
	3. Hypophosphataemic vitamin D-refractory rickets with aminoaciduria and acidosis	N or ↓	↓	↑	N or	+	+	+	++	0
	4. Cystine storage disease with vitamin D-refractory rickets	N or ↓	↓ or ↑	↑	N or	+	+	+	++	+
	5. Hypophosphataemic vitamin D-refractory rickets with hyperglycinuria	N	↓	↑	N	+	0	0	(Glycine only)	0
	6. Oculo-cerebro-renal syndrome with hypophosphataemic vitamin D-refractory rickets	N	↓	↑	N	+	0 or +	+	++	0
	B.									
	1. Rickets due to renal tubular acidosis	N	↓	↑	N	+	0	+	0	0
IV	Miscellaneous Hypophosphatasia	N or ↑	N	↓	N or ↑	0	0	0	+ (Phosphorylethanolamine only)	

0=absent. +=present. N=normal.
(Reproduced with authors' and publisher's permission; from The Diagnosis and Management of the Various Type of Rickets, Fraser and Salter, Pediatric Clinics of North America, May 1958, published by W. B. Saunders Co.)

posits. This perhaps is of significance in indicating the benign and inert character of such deposits. An attempt was made to identify these crystals by extracting them and precipitating them as crystals of various salts of cystine which they were assumed to be. Methods for the identification of these crystals are discussed by Gatzimos[4] in an article on cystinosis. However, we were unable to make a positive identification of the crystals. We have, nonetheless, because of their general morphologic features, assumed that they were cystine.

Ultimately, the diagnosis of this case and cases of this group rests on the demonstration of abnormal amino acid excretion in the urine. This is most simply accomplished by paper chromatographic analysis. The individual amino acids excreted can be identified by calculation of the RF values or by empirical comparison with the migration of known amino acid substances as controls. In Figure 1 the chromatogram demonstrates the abundant amino acid excretion and also the increased number of individual amino acids. There appeared to be 10 or more distinct lines on the chromatogram. It has been accepted that more than 4 amino acids in the urine is abnormal. Normally, glycine, histidine, serine, threonine, and occasionally lysine may be excreted; and if the individual amino acids are identified, the excretion of others than these may be considered an abnormality of reabsorption. This chromatogram is interpreted as showing an abnormal number and also an excessive amount of amino acid in the urine.

Clinical Diagnosis. This is a case of rickets with aminoaciduria, acidosis, and eventual uremia. It represents a syndrome of which we have become increasingly aware over the past few years. It also provides the opportunity to consider the collateral aspects of conditions which present simply as rickets, but in which the associated abnormalities may be of greater consequence.

REFERENCES

1. Harper, H. A. and Doolan, P. D.: Renal aminoaciduria, Clin. Chem. 9:19, 1963.
2. Fraser, D. and Salter, R. B.: Diagnosis and management of various types of rickets, Pediat. Clin. North America, May 1958, p. 417.
3. Worthen, H. G. and Good, R. A.: deToni-Fanconi syndrome with cystinosis, A. M. A. Jrl. Dis. Child. 95:653, 1958.
4. Gatzimos, Schulz and Newnum: Cystinosis—Lignac-Fanconi disease, Amer. J. Path. 31:791, 1955.

ACKNOWLEDGMENT: Photographs are presented through courtesy of A. M. Kuzma, Department of Medical Photography, Marquette University School of Medicine.

THE PRESIDENT'S PAGE . . .

We Can Learn from Others

■ THE IMPRESSIVE efforts and results obtained from other societies constitute a stimulating challenge to the members and staff of our own Society. Others must believe this too, because over 500 people were in attendance at the meetings of the American Medical Association Institute and the Medical Society Executive Association held in Chicago, August 21–22–23. The meetings were well run as usual, the speakers were excellent, presentations were well organized, and the material was outstanding in content and values.

Subjects presented were exceptionally timely and important to all of us . . . "Looking Ahead at the AMA," "Critique of Modern Day Coverage of Washington News," "*Accentuating the Positive—Reacting to the Negative*," Preview Report from the Commission on the Cost of Medical Care," "Making Health Insurance Work," . . . with ample question and answer periods.

The following are direct quotes taken out of context with infrequent designation of the speakers: "Making health insurance work . . . all depends on leadership and the giving of objective professional advice to the insurers . . . with noninterference in the patient-physician relationship." "With rising demand for major medical, the costs of medical care must be kept in balance; this can only be done with the full cooperation of the medical profession for we and the hospitals should accept major responsibility for the support of the 'Blues'."

J. C. Trexel, M.D., Chicago: "Seldom mentioned is the need for thrift, with the emphasis that we must do things thriftily to survive." F. J. L. Blasingame, M.D., AMA, Chicago: "I feel that in approaching the subject of financing medical care one must tread carefully because of the sensitive and complex inter-relationships of Blue Shield and Blue Cross, and the Blue-Shield-Cross Plans with health insurance companies. The need for honest and candid consideration of these various approaches is more urgent, however, than ever before because of the pressure from the King-Anderson type legislation . . . increased premiums . . . development of quality nursing home facilities and coming prepayment and health insurance . . . the contentious resistance to fee schedules and their inequities, and many other developments."

Continued on page 391

PRESIDENT'S PAGE *Continued from page 390*

"I feel strongly that the entire *voluntary* health insurance and prepayment movement must be preserved, but I feel equally strongly that their preservation as *free nongovernment*-controlled enterprises is not likely unless certain basic changes are made in the kind of policies that are sold to the public. Specifically, it seems to me that the prepayment approach that emphasizes first-dollar coverage, and administered pricing of vendors' services through fee schedules, must be revised if it is to remain an unsubsidized product that can be sold in a free, open market. Either the subscriber must bear a higher share of those health care costs which are expectable and recurrent or the prepayment plans will look increasingly to the federal government to do so. The deductible must be incorporated into health care policies . . . if policies are to be sold at a reasonable premium price and are to contain coverage protection against those health care costs which are most burdensome to the subscriber."

"I submit that the jolt to traditional community rating service benefit that this approach means to the Blue Plans is more than offset by the ability to understand deductible policies due to . . . unique relationship with providers of the care."

"Emphasis on the county medical societies' purposes to assist each member to practice medicine efficiently to the limit of each one's ability."

Difficult to define *high quality medical care* and one definition was roughly . . . "soundly oriented to modern scientific advances . . . services personally applied, in a climate of socio-economics." So many people confuse quantity with quality.

"Minimize the percentage of intrusion into private medical practice." "Insurance carriers deserve protection from *gougers*." "There are *punks* in every profession and vocation, and everywhere."

"Hospitals can 'goof'." "All the professions are servants of the people . . . should advance on a mutual basis . . . and not . . . ever . . . traffic on human misery."

"Physicians have the talent, ability and resources for maximum participation . . . in concert . . . to represent the group."

"Not so good to flaunt bad manners . . . nor to have an omniscient manner toward others in the team field . . ."

"Do not go in for *puppeteering* . . . moving people about . . . manipulating people. Better an attitude of self-effacement!" "American people are in danger of losing the best system of medical care in history."

"So get off your/our lackadaisical attitudes. Whack the quacks. Physicians are busy and so important to the community . . . and must not be sloganeered. Not be misled by the common *jargon* of public sectors . . . private sectors . . . and not suffer from so-called 'image neurosis'."

"More than 90 per cent of all scientists, in history, are alive today . . . and technology has superseded science in its speed of distribution and adaptation."

"In that we may get the press that we deserve, it is essential to have profound respect for public opinion . . . historically known that the winning of public support must not be left to chance."

"It appears possible that politicians et al. by a combination of propagandizing forces can 'fool most of the people most of the time'."

Continued on page 392

Fifth Annual Congress of the Professions

Money will be the subject of the 5th Annual Congress of the Professions to be held in Lansing, Michigan on February 7 and 8, 1964. This is the annual meeting of the American Association of the Professions and the Michigan association.

According to Hugh W. Brenneman, Executive Director, "the total time will not be spent on the review of how professional people can earn more money, although it is possible that that idea may be considered.

"Rather, the emphasis will be placed on where money comes from for professional education, research, and service; what effect the pressures and expenditures of money have on the practice and progress of the professions; and how the various mechanisms for paying for professional services affect distribution and delivery of such services."

Discussing topics related to the money theme will be outstanding leaders of funds and foundations, financiers, and heads of governmental financial policy-making units.

Last year's Congress drew national attention both because of its unusually high-caliber program and the attendance of representatives from 16 states.

Invited to attend and participate in the 1964 Congress are the officers and members of the State Medical Society of Wisconsin.

UW/SMS "In-Depth" Teaching Program

The first of the "In-Depth" teaching programs, developed cooperatively by the University of Wisconsin Medical School and the State Medical Society of Wisconsin, will be held on Pediatrics, Oct. 9, in Madison. The first part of the course, on Infections and Anomalies of the Urinary Tract in Children, will be held from 10 a.m. to 12 noon at the S. M. I. Auditorium, 1300 University Avenue. Dr. Charles C. Lobeck, Associate Professor of Pediatrics, will open the program with a discussion of "Consequences of Urinary Tract Infections," after which four patients will be presented for observation and discussion.

Lunch and discussion will be held at the State Medical Society building, 330 East Lakeside Street, from 12 noon to 4 p.m. The following program will be conducted: "Etiology and Treatment of Urinary Tract Infections," will be discussed by Dr. James Cherry, Assistant Professor of Pediatrics; "The Incidence of Urinary Tract Infection in Pediatric Practice," C. R. Weatherhogg, Clinical Instructor of Pediatrics; and "Recognition and Correction of Anomalies of the Urinary Tract," Dr. John B. Wear, Jr., Instructor of Surgery. The coordinator of the conference is Dr. Nathan J. Smith, Professor and Chairman, Department of Pediatrics.

Following this, one-day programs will be conducted on Neurology, Nov. 14; Cardiology, Jan. 29, 1964; Orthopedics, Feb. 20; and Endocrinology, March 19. Reservations for these meetings may be made by filling out the reservation blank on page 45.

Postgraduate Seminar in Anesthesiology

The University of Miami and University of Florida School of Medicine have announced the First Annual Postgraduate Seminar in Anesthesiology to be held in Miami Beach, Fla., Jan. 5–8, 1964.

PRESIDENT'S PAGE *Continued from page 391*

"In occupational medicine the personal physician and the plant physician are teamed together to maintain the health of the workers at home and on the job . . . in the prevention and cure of disease and injuries . . . curing illness . . . repairing injury and to follow through convalescence until full recovery at the job. Seventy-five per cent of all employees in the U.S.A. work in small plants."

"To accomplish our goals: to accentuate the positive . . . reacting to the negative . . . it is necessary to identify the power structure in each individual community."

W. J. Egan M.D.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

SEPTEMBER 1963
Vol. 62 No. 9

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EDITORIALS

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Down The Drain

■ How MUCH necessary medical care could $10,000,000 buy? How much vital research could be financed? How many fine institutions supported?

Don't look for answers from the Defense Department, for the Pentagon is now considering plans to build new hospitals which "will result in costs of $10,000,000 *more than necessary* to provide adequate hospital facilities for joint service use, "according to Comptroller General Joseph Campbell, head of the General Accounting Office.

Two years ago the Joint Economic Committee of Congress demonstrated that the separate armed services were wasting untold millions in the medical field because each branch insisted on maintaining its own medical facilities. It pointed to the Air Force hospital at Langley Air Force Base, Virginia, with 217 beds and an average census of 52, while six miles away the Army operated a hospital at Fort Monroe, Virginia, with 141 beds and only 20 patients.

In the San Francisco Bay Area alone, said Mr. Campbell, the Defense Department is wasting $8,200,000 annually because of duplication of facilities at the Army's Letterman General in San Francisco and the Navy's Oak Knoll Hospital across the bridge in Oakland.

A series of congressional committees, two Hoover commissions and the United States Budget Bureau have repeatedly recommended that the medical services of the armed forces be combined in order to save money—and, unquestionably, to promote efficiency and to improve the quality of medical care. So far, the services have successfully resisted attempts to consolidate their medical activities.

In the face of ever increasing defense spending it is probably too much to expect the Pentagon to retain a sense of proportion when it comes to hospitals, doctors, nurses and equipment. Overpaying ten million tax dollars is a trifle compared to the cost of a couple of shoots at Cape Canaveral. And probably without much effort, an investigator could turn up examples of military waste that would make the $8,200,000 unnecessarily spent in the San Francisco area look like small change lost in the lining of a coat. All that the harassed taxpayer can do is hope that the congressional committees, the Hoover commissions and the Budget Bureau, all of which use up their own quota of public money,

may someday have a cumulative effect that will compel the Pentagon administration to go easy on unnecessary spending.

At the same time, it is to be hoped that the taxpayer will acquire some idea of gigantic boondoggle the proponents of tax-supported medicine are hoping to impose on him. If the "government mind" can waste so many millions providing medical services for the relatively few people in the defense establishment, think of the billions they would waste providing medical care for the entire population.—D. N. G.

Spare the Young

The resolutions of the several state medical societies against cigarette smoking because of its link with pulmonary malignancy emphasize the seriousness with which doctors view the use of tobacco. But inveighing against smoking is like inveighing against sin: much agreement, much non-compliance. The confirmed smoker will concede it is a good idea to smoke less, and he will light up as he says so.

A few persons addicted to tobacco will probably give up smoking because of the increased possibility of cancer and heart disease; a few more will cut down, but the majority will fatalistically continue to yield to the habit.

Non-smokers, however, can be salvaged. Young people who are approaching an age when smoking begins as a habit can be saved from addiction. To do this, the social climate must be changed so that smoking is looked upon as it used to be—a damned dirty habit, and a vice.

Cigarette companies should be made to appreciate their accountability for increasing the chance of cancer for millions of young people. Since relatively few persons start or stop smoking after reaching maturity, the tobacco companies know that their most productive advertising must be directed to the young. By making cigarette smoking appear to be a concomitant of social success, of romance, of social grace, the cigarette companies seek to lure impressionable youngsters into the clutches of lifelong addiction. By and large, they succeed.

The idea the advertisements and radio-television commercials convey is that smoking is a "right" practice, a smart thing to do, a mark of maturity. By peddling this message, spurious as it is, the tobacco companies and their advertising agencies bear a tremendous burden of guilt for hooking unsuspecting young people on a habit that seems to increase their chances for an earlier death.

Nobody can expect the large cigarette manufacturers to go out of business because of the findings of medical research. But it is not too much to expect that the sure knowledge we now have about the connection of cigarette smoking and cancer will impel them to quit advertising the high road to a fatal disease as a social virtue.—D. N. G.

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin.

Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills.

In any event, all contributions to the Foundation are deductible for income tax purposes.

Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.

STATISTICS ON DIABETIC PATIENTS CITED

It is estimated that 1 American of every 60 is a diabetic, and that there are approximately three million diabetics in the nation today. Of this number about 1,600,000 know that they are diabetic, and roughly 1,400,000 are unaware of their condition.

Approximately 5,125,000 other persons living today are potential diabetics. About 75,000 persons are known to become diabetic each year.

Diabetes is hereditary. Of the total population of the United States, one out of every four persons—or 45 million people—are believed to be diabetic "carriers."

More than 85 per cent of all diabetics are over 45 years old. Three out of five in this age group are women, and six out of seven were overweight when their condition was discovered.—Reprinted from *Journal of the Michigan State Medical Society*, March 1963.

the wisconsin medical journal

VOLUME 62/NUMBER 10 OCTOBER 1963

Transient and Persistent Duodenal Obstruction Secondary to Acute Pancreatitis

By I. N. NEVIN, M. D., Rhinelander, Wisconsin

■ COMPLETE MECHANICAL obstruction of the duodenum is an extremely rare complication of acute pancreatitis. A review of the literature revealed only one case.[1] However, a few cases of small intestinal obstruction distal to the duodenal loop have been reported.[2] In a discussion of complications of pancreatic disease, Hardy and Bowlin stated that mechanical obstruction of the duodenum or the jejunum near the ligamentum of Treitz is not infrequent for they had encountered three such complications in one year.[3] In one case which they reported, the obstruction was at the duodenojejunal junction. The present report, however, is concerned primarily with obstruction of the duodenum proper, secondary to acute pancreatitis.

Case Reports. *Case 1:* A 72-year-old white widow was admitted to a hospital for the first time on Jan. 25, 1962, with the chief complaint of upper abdominal pain of one day's duration. Physical examination revealed a fairly well-nourished woman in acute distress. There was exquisite tenderness upon palpation of the upper abdominal field. The blood leukocyte count was 20,050. The gallbladder was not visualized with oral cholecystography.

Doctor Nevin is Director, Department of Radiology, St. Mary's Hospital, Rhinelander.

Presented at the 122nd Annual Meeting of the State Medical Society of Wisconsin, May 8, 1963, Milwaukee.

A complete study of the gastrointestinal tract revealed no evidence of any intrinsic abnormality. However, in the upper abdominal field just to the right of the midline a poorly defined soft tissue mass was interpreted as representing either a hydrops of the gallbladder or enlarged head of the pancreas. The patient was treated symptomatically for two weeks and was discharged from the hospital apparently free of symptoms. A week later she was admitted to the same hospital at which time a calculus-bearing gallbladder was removed. At the operation fresh adhesions were found around the gallbladder which were assumed to be caused by recent cholecystitis.

On the sixth postoperative day, the patient began to vomit intermittently and complained of upper abdominal cramps. The significance of this was not appreciated until the vomiting became persistent requiring continuous gastric suction and intravenous feedings. A roentgenogram of the abdomen revealed a striking absence of any gas beyond the dilated stomach. Upon ingestion of a water-soluble contrast medium (Hypaque), complete obstruction of the outlet of the stomach was noted (Fig. 1). Three days later an exploratory laporatomy was carried out. A large inflammatory, fibrinous and extremely friable mass was found around the

Fig. 1—Roentgenogram of the abdomen two hours after the ingestion of the oral radiopaque medium. Note complete obstruction of the duodenum.

Fig. 2—Roentgenogram of the abdomen four hours after ingestion of the radiopaque medium. Note the contrast medium in the duodenal loop. Arrows indicate the site of gastrojejunostomy. No contrast medium seems to have reached the jejunum.

duodenal loop occluding its lumen completely. The pancreas appeared to be enlarged. A posterior gastrojejunostomy was established. The patient did well for three days and then signs of high intestinal obstruction developed.

X-ray examination of the abdomen, after ingestion of oral diatrizoate sodium, revealed obstruction of the gastrojejunal anastomosis (Fig. 2). Serum amylase at this time was 90 Somogyi units per 100 ml. (normal range 60 to 160). Because of severe electrolyte imbalance, the patient was transferred to this hospital on April 1, 1962. After correction of the serum chemical derangement, a surgical exploration was performed. Loops of injected and edematous intestine were adherent to the peritoneal wound surface by fibrinous and fibrous adhesions that bled briskly. There was grayish-white necrotic material superior to the duodenum and in the gallbladder bed. The head of the pancreas was enlarged and firm on palpation. The jejunum immediately distal to the gastrojejunostomy was narrow and firm. Because of the precarious condition of the patient, a side-to-side enteroenterostomy around the obstruction was performed. She recovered slowly and left the hospital five weeks later. She has remained symptom free to this date.

Case 2: A 47-year-old white married man entered this hospital on Apr. 24, 1962, with the chief complaint of severe upper abdominal pain, nausea and vomiting of 12 hours' duration. Physical examination revealed a rather obese man in severe distress, perspiring profusely. A scout film of the abdomen revealed remarkable absence of any gas in the large or small bowel. Only a single dilated "sentinel" loop of small intestine could be seen in the upper abdominal field. There was a fluid level in this loop on the lateral decubitus film. Fifty ml. of diatrizoate sodium diluted in a glass of water was administered orally to determine if there was a high intestinal obstruction. A roentgenogram of the abdomen one and one-half hour later showed no evidence of passage of contrast medium beyond the duodenal bulb

(Fig. 3). This was interpreted to be compatible with the clinical impression of acute pancreatitis.

The blood leukocyte count was 16,300 with a marked shift to the left. Serum amylase determinations were as follows: April 24 a.m., 7.1; April 24 p.m., 74.0; and April 26, 152.0, all in Somogyi units per 100 ml. (normal range 60 to 160) with serum lipase of 2.5 sigma units (normal range up to 1.00). Serum total protein was 4.6 Gm. per 100 ml. with an abnormal electrophoretic pattern. The patient was treated medically. The symptoms of duodenal obstruction began to abate on the third hospital day and with continuous conservative management he improved sufficiently to be discharged on the fourteenth hospital day. Six months later the patient was found to have an upper abdominal mass which was believed to be caused by formation of a pancreatic cyst. At the operation, the mass was found to be the left lobe of a large cirrhotic liver. The pancreas was noted to be firm in some areas, and the entire gland was larger and harder than normal.

Case 3: A 20-year-old divorced white woman entered a hospital on Aug. 19, 1962, with the chief complaint of abdominal pain and vomiting of 24 hours' duration. She stated that she had experienced similar episodes intermittently for the previous four years. Physical examination revealed a pale young woman in acute distress with generalized abdominal pain and considerable guarding over the epigastrium. The initial blood leukocyte count was 9,500, but in a repeat study two days later it was 18,700 with marked shift to the left.

Because of continuous nausea and vomiting, intravenous cholecystography was performed on the third hospital day. The gallbladder was not visualized. Upon roentgen examination of the upper gastrointestinal tract, a considerable delay in the passage of barium through the duodenum was noted. A film of the abdomen obtained three hours after the ingestion of a barium meal showed only a thin streak of barium reaching the proximal jejunum (Fig. 4). The possibility

Fig. 3—Roentgenogram of the abdomen 90 minutes after ingestion of oral radiopaque medium. Note the "sentinel" loop and the striking absence of any gas elsewhere in the gastrointestinal tract in a patient who is acutely ill. No contrast medium can be seen beyond the dilated stomach.

Fig. 4—Roentgenogram of the abdomen three hours after ingestion of barium. Note the irregularity of the duodenal loop and the minute streak of barium in the proximal jejunum.

of pancreatitis was suggested. Serum amylase was 1,900 Somogyi units per 100 ml., and urine amylase (a random specimen of 150 ml.) was more than 2,500 units (normal range 60 to 160). The icteric index at this time was 15.6 with serum bilirubin of 2.6 direct and 5.6 mg. per 100 ml. indirect. A diagnosis of pancreatitis was made, and the patient was treated conservatively. Vomiting and severe upper abdominal pain subsided on the third hospital day, and the patient was discharged on the ninth hospital day relatively symptom-free.

On Sept. 14, 1962, she entered this hospital without any presenting acute symptoms. Her serum amylase was 30 Somogyi units per 100 ml. Other routine laboratory findings were within normal limits. Cholecystography revealed numerous small stones within the gallbladder. A cholecystectomy was performed on the fourth hospital day. There was "subacute" inflammation of the gallbladder and slight dilatation of the cystic duct. The common duct was explored, but no stone was found. No gross evidence of fat necrosis was found within the exposed field of operation, but the lesser peritoneal sac was not opened for inspection of the pancreas. The postoperative course was uneventful, and the patient was discharged after 11 days.

Discussion. The onset of pancreatitis is often abrupt and invariably the predominant symptoms are acute upper abdominal pain, nausea, and vomiting. In many cases there is an associated cholecystitis and cholelithiasis as demonstrated in two (1 and 3) of the three cases presented here. Hence, frequently the clinician is preoccupied with abnormality of the gallbladder and may overlook the possibility of pancreatitis. Since the treatment of acute pancreatitis is conservative and since there is an increase in mortality rate if the patient is operated upon,[4] every effort should be made to arrive at a correct diagnosis. When persistent vomiting is the predominant symptom, the possibility of a high intestinal obstruction is usually entertained and the assistance of the roentgenologist may be sought. An orally administered water-soluble contrast medium can be of help in determining the site of obstruction. It is emphasized that the possibility of pancreatitis as a cause of intestinal obstruction should be considered in the differential diagnosis by the roentgenologist. This might prove extremely helpful in the management of the patient and the choice of treatment.

Grollman and associates[5] observed the presence of localized ileus ("sentinel" loop) in pancreatitis. This is believed to be caused by seepage of pancreatic enzymes as suggested by Metheny and associates.[6] An adequate description of the roentgen appearance of functional and anatomical changes of the duodenal loop in pancreatitis also has been given by Poppel.[7] However, complete or partial mechanical obstruction of the duodenum secondary to pancreatitis has not been hitherto sufficiently emphasized. Brust and Chen[1] quote two instances of complete obstruction of the duodenum secondary to pancreatitis, but these cases had additional complications. One patient had an annular pancreas, and the obstruction of the other patient followed a closed abdominal injury.

The mechanism of complete obstruction of the duodenum in Case 1 of this report appeared to be due to an inflammatory mass in the region of the head of the pancreas and the duodenal loop. This obstruction was initially bypassed by means of a gastrojejunostomy. However, obstruction recurred at the site of anastomosis requiring a second bypass (enteroenterostomy). Although the obstruction was complete in Case 2, it spontaneously cleared following a period of conservative medical management. The same appeared to be true for Case 3.

It is possible that the severity and obstinancy of obstruction in the first case was precipitated by cholecystectomy a short time after an attack of pancreatitis. After the nonoperative treatment in Cases 2 and 3, there were no stormy consequences as in Case 1.

Summary. Three cases of complete and transient mechanical obstruction of the duodenum secondary to pancreatitis have been presented. It is recommended that the possibility of pancreatitis should be considered in the differential diagnosis in all cases of suggested high intestinal obstruction. This might prove extremely valuable in the choice of the treatment.

1044 Kabel Avenue.

ACKNOWLEDGMENT: The author wishes to thank Dr. R. G. Baker, Tomahawk, and Dr. G. F. Pratt, Rhinelander, for permission to use Case 1; thanks also to Dr. I. E. Schiek, Jr., Rhinelander, and Dr. V. M. Bartley, Eagle River, for contributing Cases

2 and 3 respectively. Gratitude is expressed to Dr. W. S. Bump, Chief of Surgery, St. Mary's Hospital, Rhinelander, for his helpful suggestions in preparation of the manuscript.

REFERENCES

1. Brust, R., Jr. and Chen, K.: Acute hemorrhagic pancreatitis complicated by duodenal obstruction; report of case, Am. J. Roentgenol. Rad. Th. & Nuclear Med. 87:732–735 (Apr) 1962.
2. Moore, T. C.: Jejunal obstruction as complication of acute hemorrhagic pancreatitis, A.M.A. Arch. Surg. 73:977–980 (Dec) 1956.
3. Hardy, J. D. and Bowlin, J. W.: Some complications of pancreatitic disease—illustrative cases with notes on management, Ann. Surg. 145: 848–856 (June) 1957.
4. Paxton, J. R. and Payne, J. H.: Acute pancreatitis; statistical review of 307 established cases of acute pancreatitis, Surg. Gynec. & Obstet. 86:69–75 (Jan) 1948.
5. Grollman, A. I., Goodman, S. and Fine, A.: Localized paralytic ileus, an early roentgen sign in acute pancreatitis, Surg. Gynec. & Obstet. 91:65–70 (July) 1950.
6. Metheney, D., Roberts, E. W. and Stranahan, A.: Acute pancreatitis with special reference to x-ray diagnosis, Surg. Gynec. & Obstet. 79:504–508 (Nov) 1944.
7. Poppel, M. H.: Roentgen manifestations of relapsing pancreatitis, Radiology 62:514–521 (Apr) 1954.

CHEST PHYSICIANS ANNOUNCE 1964 ESSAY CONTEST

The American College of Chest Physicians offers three cash awards to be given annually for the best essay prepared by undergraduate medical students on any phase of the diagnosis and/or treatment of chest diseases (heart or lungs).

The First Prize will be $500; Second Prize, $300 and Third Prize, $200. Each winner will also receive a certificate of merit. A trophy inscribed with the name of the winner and the name of his school will be presented to the winner's school.

The winners will be announced at the 30th Annual Meeting of the American College of Chest Physicians, to be held in San Francisco, June 18–22, 1964. Contest closes on March 15, 1964.

The official application form, sample copies of the journal, and additional information may be secured by writing Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois 60611.

LONG-TERM BLOOD PRESERVATION A REALITY

HAYNES, L. L., et al.: *J. Michigan S.M.S.* 1509–1512 (Dec) 1962.

The long-term preservation of living tissues is now a reality. In the case of blood, the storage time has been extended to five years.

The method of long-term blood preservation used at the U. S. Naval Hospital, Chelsea, Massachusetts, employs the Cohn fractionator, a specialized centrifuge which separates the erythrocytes from its plasma and other cellular elements. At the same time, this fractionator allows for the replacing of the intracellular water with a 50 per cent glycerol solution. The erythrocytes, protected against the damaging effects of freezing by the glycerol, are bagged in a plastic envelope, and frozen to a —80° C. for storage in an ametabolic state. The frozen blood can be stored either in mechanical reefers as we do in our blood bank, or packed in dry ice for temporary storage or transportation. When blood is needed, days or years later, the frozen units are thawed in a 37° water bath; the glycerol is removed again by using the Cohn fractionator, and washing with decreasing concentrations of glycerol.

The deglycerolized erythrocytes are resuspended either in their own plasma, which was frozen as a separate unit after the original separation, or in a 5 per cent serum albumin menstruum. Blood so reconstituted may then be safely kept in the standard blood bank refrigerator at 4° C. for at least 21 days. The process of glycerolization, freezing and deglycerolization does not alter the grouping, typing or cross-matching reactions. Routine methods are employed; all units are grouped and typed before and after freezing.

The vast majority of frozen blood cells are given resuspended in the serum albumin menstruum, although the red cells resuspended in their original plasma are also available. The reason for this trend has been the many growing advantages of frozen glycerolized red cells resuspended in the 5 per cent albumin menstruum. It should be re-emphasized that this blood contains no anticoagulants, preservatives or additives, and it may be kept for at least 14 days in the refrigerator at 4° C. It can be tailored to suit the individual patient's needs, adding those elements of the blood as required.

The preservation of whole blood is now a reality, and has functioned for the past two years at a full clinical level at the U. S. Naval Hospital, Chelsea, Massachusetts.

The red cells resuspended in a serum albumin medium in preference to plasma has been shown to be adequate for blood volume replacement even in massive transfusion, and many new advantages are becoming evident.

CORRECTION

An inadvertent error occurred in the July issue, page 324, Comments on Treatment article "Oral Hypoglycemic Agents," by Deane N. Calvert, Ph.D. The last two lines of paragraph one should have read: ". . . deficiency has led to a continuous search for alternative methods of treatment."

TETANUS INFECTION

By HENRY BROWN, M. D.

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■ TETANUS is an infection known chiefly because of the severe toxicity of the endotoxin of Clostridium tetani on the central nervous system. It was described in ancient times, and is marked by stiffness of the neck and inability to open the jaws (trismus) from which the name "lock-jaw" comes.[1] Along with this the corners of the mouth often turn up in a characteristic grimace called the "risus sardonicus." As the condition progresses there is difficulty swallowing and breathing, leading on the slightest stimulation to generalized muscular spasms with arching of the neck and back in a position termed opisthotonus.

Formerly tetanus was very common, especially in wartime, but it has become relatively infrequent, since tetanus toxoid has been used for mass immunization. Many physicians are not presently familiar with techniques of therapy merely because they have not dealt with this infection. The condition is, however, seen often enough that one must not only actively seek to prevent it but also must be familiar with signs, symptoms, and treatment. The following case summary will illustrate some principles of management.

Case Report. A 72-year-old white male farmer was admitted to the hospital with the chief complaints of a stiff neck, and difficulty opening his mouth and swallowing for the previous 12 hours. He related that 4 days prior to admission he had been scratched on the dorsum of the right forearm by a pig causing a 3 mm. abrasion. At the time of admission he was unable to bring up rapidly accumulating saliva and tracheobronchial secretions. In addition he had intermittent generalized muscle spasms accompanied by respiratory distress and cyanosis. Between paroxysms he was alert and well oriented.

A working diagnosis of tetanus was made and the patient was placed in a dark quiet room. Since he had never been immunized and the skin test for serum sensitivity was negative, he was given 40,000 units of tetanus antitoxin intramuscularly and 40,000 units intravenously. He was also given 600,000 units of penicillin every 6 hours. The muscular spasms and cyanosis soon became so severe that an emergency tracheotomy was performed. Respirations were assisted with a Bird respirator attached to the tracheotomy tube. The wound was then excised and a 3 cm. cruciate incision was made through the area for drainage. Later a wider debridement measuring 3.5 cm. in diameter was carried out, including all the tissues of the cruciate incision, and extending down to the fascial covering of the muscles of the right forearm. The periphery of the excised area was injected with 200,000 units of tetanus antitoxin daily for 10 days and then every second day for 10 additional days. Smear and cultures, both aerobic and anaerobic, of the tissue failed to reveal any organisms. This is a relatively common occurrence in these infections.

Paraldehyde, administered intramuscularly, as well as rectal instillation of paraldehyde in oil, were given initially in an attempt to control muscular spasms. Later 100 mg. of amobarbital (Sodium Amytal) and 100 mg. of diphenylhydantoin (Dilantin) sodium were given intramuscularly every three to four hours to supplement this. Severe muscle spasms and opisthotonus continued to occur, however, until 25 mg. of curare in 1 ml. of oil (Tubadil) was administered. It should be emphasized that the use of curare is an important but potentially dangerous part of the treatment, requiring very careful supervision. After warming, curare in oil is given by a single daily intramuscular injection. Respiratory arrest may occur, particularly if the dose is divided and given by multiple small injections at different sites, since the latter procedure may cause absorption to become too rapid. Because of this, the person administering the drug must be thoroughly familiar with methods of artificial respiration. In addition, if apnea occurs, neostigmine (Prostigmine) may be used to counteract the effects of cu-

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rare. Neostigmine, however, may increase secretion. Thus atropine also must be given at the same time to prevent respiratory distress from such secretion.

The patient required several transfusions for the anemia which developed during the course of the infection. Intravenous feeding was soon supplanted by tube feeding with a small polyethylene nasogastric tube and a Baron food pump. An 1,800-calorie liquid diet diluted to 2,500 ml. with water was given daily. Loss of bowel control was a nursing problem. Despite use of sterile techniques in passing a Foley catheter to control incontinence, a Pseudomonas urinary tract infection occurred. This was treated by bladder irrigations with 1:5000 potassium permanganate in water and furantoin (Furadantin) given orally. Neosporin ointment was placed in his eyes daily for treatment of conjunctivitis. Pneumonitis and pleural effusion developed despite meticulous attention to tracheobronchial aspirations and the use of parenteral penicillin. Digitoxin was needed for the treatment of congestive heart failure. Later there were periods of apnea which were attributed to a central nervous system origin from carbon dioxide narcosis. An accumulation of carbon dioxide had occurred from an alveolocapillary block associated with interstitial edema secondary to prolonged positive pressure respiration. This was treated by adding epinephrine to the respiratory nebulizer and by gradually reducing the inflation pressure exerted by the respirator. He responded well to this. Twenty-five days following admission the patient began to try to talk and would respond to commands. Three weeks later he was quite alert, afebrile, and no longer required tetanus antitoxin or digitoxin. The pleural effusion and pneumonitis gradually cleared, and antibiotics were discontinued.

The patient experienced difficulties moving his arms and legs due to prolonged spasms and wasting, but considerable improvement was obtained by physiotherapy. He was discharged feeling quite well, and fully oriented three months after admission, but still requiring treatment in physical medicine.

Discussion. Several points are worth emphasizing. The mere presence of tetanus organisms in a wound does not cause tetanus infection. Additional factors are needed to trigger virulence, such as the presence of injured tissues with low oxygen tension, secondary infection, or the introduction of certain salts commonly contained in earth, as calcium chloride. It should also be noted that the vegetative forms may disappear, but spores may remain quiescent for months in wounds, then suddenly cause clinical tetanus infection when proper conditions appear.[2] Often the injury causing infection is trivial or not even remembered, but knowledge of its location may be vital, for treatment may fail unless a focus of continued reinfection is excised. Early radical debridement is therefore very important. Tetanus antitoxin is injected locally and systemically to neutralize freshly released toxin, but no known treatment can save the patient when a lethal dose of toxin has become fixed to central nervous system tissue. A period of two to four weeks is usually required for sublethal doses of toxin to be released from the central nervous system and excreted from the body.[3]

The outlook has been reported to be better in tetanus for younger patients. In the 15 cases treated here since 1953, however, there were 4 deaths, the ages being 8, 28, 59, and 67, with an equally random age distribution among those recovering. Prognosis becomes less favorable as the incubation period shortens, mortality rising sharply when it is less than 10 days.[1]

Clostridium tetani are anaerobes which are difficult to grow and it is not unusual to fail to find them on cultures of wounds of patients with clinical manifestations of tetanus. Of the 15 cases cited above, 5 had smears read as being positive for Clostridium tetani, but in only one instance could the organism be cultured. In another reported series Clostridium tetani was cultured from 13 of 47 cases.[1]

Treatment of this condition is a cooperative team effort and the surgeon should obtain all possible assistance from the anesthesiologist, the internist, the neurologist, and the urologist, as well as the physicians from the physical medicine and laboratory services.

The most effective prevention of tetanus is mass immunization with tetanus toxoid. The Committee on Trauma of the American College of Surgeons recommends alum precipitated toxoid, but both this and fluid toxoid were used with equal success by the Armed Forces in World War II.[1] While there is evidence that the usual series of three

toxoid injections confers very long lasting immunity, the antibody titer progressively falls over the years, so that it may reach levels considered too low to offer satisfactory protection. Thus it would be prudent to advise a booster dose of tetanus toxoid at least every 4 years as well as following a serious injury.[4] In a few instances when a period of greater than 10 years has elapsed since the last toxoid injection, both toxoid and antitoxin may be given simultaneously at different injection sites.

Intradermal toxoid is being tried for rapid production of active immunity to replace passive immunization on an experimental basis. Since this new method has not been sufficiently evaluated, it is not yet recommended for general use.[5]

For many years the usual dose of antitoxin for nonimmunized patients not sensitive to the serum has been 1,500 units. Many now believe that if the injury is serious enough to require tetanus antitoxin, a minimum of 5,000 units should be administered.[4,6] Larger injections also do away with the need for re-injecting in 6 or 7 days for serious tetanus-prone injuries at a time when antibody titers begin to fall, but when sensitivity to the serum may appear. The policy here has been to give 1,500 to 3,000 units of antitoxin to patients with wounds in which there is the potential, but no great danger of tetanus infection. An example of an injury of this type would be a 1 cm. puncture wound of the foot from a rusty nail, which has been opened, cleansed, debrided and treated with systemic antibiotics. Larger contaminated wounds are treated with a minimum of 5,000 units.

If the nonimmunized patient is sensitive to horse serum, he may be skin tested with bovine or avian sera. While patients sensitive to all sera may very cautiously be given antitoxin in small increments, this may at times do little for providing passive immunity. This is because the foreign protein of the serum may be rejected by the patient almost as soon as he receives it.

Since there is always the risk of reaction to serum once it has been given, it should not be necessary to repeat it for future injuries. This means that each nonimmunized patient should be given a course of tetanus toxoid as part of the treatment of his injury. If large doses of antitoxin, of the order of 10,000 units are administered, this may nullify effects of the first toxoid injection if it is given simultaneously so that in these instances one may wait several weeks before beginning active immunization.[7]

Several antibiotics have been found effective against the vegetative form of Clostridium tetani, among them penicillin, tetracyclines, and chloramphenicol.[6] If the patient with a tetanus-prone wound is sensitive to sera, a course of one of these drugs after thoroughly cleansing and debridement may give adequate protection.

Summary. The principles for treating tetanus have been discussed by presenting a case summary. The need for adequate and early debridement of the wound is stressed. Treatment is a team effort including surgeon, anesthesiologist, internist, neurologist, and urologist, as well as physicians from the laboratory and physical medicine services. Passive immunity should be conferred by tetanus antitoxin if there is the possibility of tetanus infection and the patient has not been previously immunized. A very important part of the treatment of such patients should also be active immunization against the disease. Antibiotics are helpful in preventing the infection, especially for those who are sensitive to antitoxin. The best prophylaxis against tetanus, however, is mass immunization with tetanus toxoid.

REFERENCES

1. Eaton, L. M., et al.: Symposium on tetanus, Proc. Staff Meetings Mayo Clin. 32:141–168, 1957.
2. Topley, W. W. C., and Wilson, G. S.: Principles of Bacteriology and Immunity, Baltimore, William Wood Co., 1938, 2nd ed., pp. 1386–1388.
3. Crandell, D. L., and Whitcher, C. E.: Control of neuromuscular manifestations of severe systemic tetanus, J.A.M.A. 172:15–19, 1960.
4. Harrison, H. L., et al.: Management of Fractures and Soft Tissue Injuries, Philadelphia, W. B. Saunders Co., 1961, pp. 164–170.
5. Hampton, O. P., and Hard, J.: Active immunization against tetanus with intradermal toxoid, Surg. Gynec. & Obst. 109:222–223, 1959.
6. Filler, R. M., and Ellerbeck, W.: Tetanus prophylaxis, J.A.M.A. 174:83–86, 1960.
7. Edsall, G.: Specific prophylaxis of tetanus, J.A.M.A. 171:417–427, 1962.

GREEN COUNTY'S ADULT TETANUS IMMUNIZATION CLINICS

In 1962 three deaths from tetanus shocked Green County communities and led, in November and December, to two series of adult immunization clinics. These were planned by members of the Green County Medical Society and the health committee of the Public Health Nursing Service. Altogether, 2,356 persons were immunized, representing 12.7 per cent of the county population 14 years of age and older.

Green County is not unfamiliar with immunization clinics. There have been mass immunization programs for school and preschool children since 1936 when diphtheria immunizations and smallpox vaccinations were given. In 1947 tetanus immunization was added and since 1953, diphtheria, tetanus, and pertussis immunizations and smallpox vaccinations have been offered. Adults, however, have never been included. Even on a statewide basis, information about adult participation in immunization clinics is scanty; therefore, we believe that a review of the organization of the Green County program and an analysis of the records may be useful to others.

Two series of clinics were held:

Monticello	November 14	December 12
Monroe	November 16	December 14
New Glarus	November 19	December 17
Albany	November 20	December 18
Brodhead	November 11	January 8

Arrangements were made to use public buildings which were centrally located, and clinic hours were scheduled so that people could visit easily and physicians were available. One and one-half hour clinics were held between 10:30 a.m. and 3:00 p.m., the exact hours varying to suit the physicians involved. An evening clinic was scheduled in Monroe, the largest community, on the evening that stores were open.

Disposable units of tetanus antigen were used to facilitate the administration of the injections and to minimize danger of infections and inaccurate dosage. Volunteers helped with registration, preparation of the arms, and record keeping. People were given wallet-sized cards with a record of their tetanus immunizations. A 50-cent charge was made for each injection, and medical indigents were offered their injections free of charge. Interestingly enough, everyone paid.

There was no essential difference in the participation rates of the males in the county and the city; however, there was a significantly higher rate of participation among the females in Monroe city, than among females in other parts of Green County.

It was gratifying to see that persons who were exposed to the greatest risk of tetanus infection participated in a great number. About 20 per cent of the population, those between 25 and 50 years of age, availed themselves of immunization. Our big

TABLE 1—*Rates of Participation of the Population* by Sex and by Residence*

Males

Residence	Male Population Ages 14 Years and Older	No. Receiving Injections	% of Eligible Population Participants
Monroe City	2510	333	13.3
Other Green Co.	6451	803	12.4
Total	8961	1136	12.7

Females

Residence	Female Population Ages 14 Years and Older	No. Receiving Injections	% of Eligible Population Participants
Monroe City	2517	437	17.4
Other Green Co.	6711	734	10.9
Total	9228	1197	12.7

*Population estimate based on 1960 census.

TABLE 2—*Rates of Participation of the Population by Sex and by Age*

Males

Age Groups in Years	Male Population in Age Groups	No. Receiving Injections	% of Eligible Population Participants
14–19	1158	80	6.9
20–24	608	100	16.4
25–49	3704	678	18.3
50 and over	3491	301	8.6
Total	8961	1159	

Females

Age Groups in Years	Female Population in Age Groups	No. Receiving Injections	% of Eligible Population Participants
14–19	1064	63	5.9
20–24	676	89	13.2
25–49	3767	764	20.2
50 and over	3721	281	7.6
Total	9228	1197	

TABLE 3—*Immunization Needs of Participants by Sex and Residence*

Males

Immunization Needs	Monroe City		Other Green County		Totals	
	#	%	#	%	#	%
Series of 2 Injections	205	61.5	482	60.0	687	60.4
Booster	99	29.7	242	25.7	341	30.2
Incomplete	29	8.8	79	14.3	108	9.4
Total	333	100.0	803	100.0	1136	100.0

Females

Immunization Needs	Monroe City		Other Green County		Totals	
	#	%	#	%	#	%
Series of 2 Injections	348	79.6	550	74.9	898	76.7
Booster	50	11.4	121	16.4	171	14.6
Incomplete	39	9.0	63	8.7	142	8.7
Total	437	100.0	734	100.0	1171	100.0

TABLE 4—*Immunization of Participants by Age and Sex*

Males

Immunization Needs	Ages in Years							
	14-19		20-24		25-49		50 and over	
	#	%	#	%	#	%	#	%
Series of 2 Injections	6	7.5	33	33.0	436	64.3	226	75.1
Boosters	63	78.8	60	60.0	183	26.9	41	13.6
Incomplete	11	13.7	7	7.0	59	8.8	34	11.3
Total	80	100.0	100	100.0	678	100.0	301	100.0

Females

Immunization Needs	Ages in Years							
	14-19		20-24		25-49		50 and over	
	#	%	#	%	#	%	#	%
Series of 2 Injections	10	15.9	56	63.9	619	81.0	234	83.3
Boosters	48	75.6	27	30.3	77	10.1	26	9.2
Incomplete	5	8.5	6	6.8	68	8.9	21	7.5
Total	63	100.0	89	100.0	764	100.0	281	100.0

surprise was the high participation of young adult males whereas nationwide experience with polio clinics shows that this age group usually avoids participation in any public program. The 8 per cent participation of population over 50 years of age reflects the diminishing interest of the older population in this type of program.

Only 9 per cent of the participants did not complete their immunizations. This rate is the same for both sexes and for residents of the county and city.

"Incomplete" means a person who needed two injections and received only one. Many of these went to their family physicians to complete the series. These figures are not available, however. Seventy per cent of the males needed the basic series, and 90 per cent of the females living in the city and 85 per cent of the females from the county needed both injections. Probably males had their primary immunization in the army or in connection with their jobs.

Only a small number of the participating young persons (aged 14 to 19) needed a primary series. Probably this age group had their immunization in schools. The young male adults needed more booster injections, whereas the females in this group needed more primary injections. The reason for this may be, again, job requirements and army experience. Among the older adults, the need for primary series is obvious from the table. The most striking finding in this tabulation is that the percentage of persons in both sexes who need the primary injections increases in all categories by increasing age groups.

Summary

In Green County, 12 per cent of the eligible population participated in an adult immunization clinic. The participation rates were higher for males, and they were higher among residents of the city as compared to the residents of the county.

Twenty per cent of the eligible population, aged 25 to 50, received immunization for tetanus. The need of primary immunization is greater as the population groups become older, and this need is greater among females as compared to males.—
JOSEF PREIZLER, *M.D., Director, Bureau of Communicable Diseases, State Board of Health,* Madison; MARTHA TSCHUDY, *R.N., Green County Public Health Nurse,* Monroe; and KATHRYN ETTER, *R.N., Monroe Joint District School Nurse,* Monroe.

SALMONELLA IN THE SHELL

A Salmonella recently isolated at a Milwaukee hospital from a 10 month old infant with a severe gastroenteritis was found to be *Salmonella poona.* This is one of the rare types and has not previously been encountered in this laboratory. Investigation by the pathologist revealed that the infant had been given a small turtle to play with and had placed it in her mouth. The turtle was not available for examination as it had died and been discarded. Of course, many other pets carry other types of Salmonella, and parents should be alert to the possible exposure of their children to infection of this nature.—STATE LABORATORY OF HYGIENE NEWSLETTER.

Farm Accidents Occurring in Children

By GEORGE L. LUCAS, M. D. and HERMAN W. WIRKA, M. D.
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■ MECHANIZATION has brought to the farmer ever increasing ease in planting and harvesting his crops with a greater margin of profit; however, the increasing use of complex machinery has provided a serious hazard to life and limb. Accidents involving farm machinery are common and are perhaps even more tragic when they involve the life or extremity of a child, but serious injuries to children on farms continue to exact a dreadful toll of mangled limbs. Despite continued advances in safety engineering principles as practiced by the manufacturer of corn pickers, hay balers, and mowers, children still manage with alarming frequency to find their way into the cutting blades of such machinery. Natural curiosity and lack of respect for dangerous equipment, coupled with parental neglect or indifference, would appear to be the cause of this problem.

Large industrial corporations have proved that strict enforcement of safety rules plus adequately shielded machinery will result in a low accident rate. The manufacturer can provide all types of safety devices for the machine which he produces, but if the farmer removes the cover from the power take-off, as is frequently done, we cannot expect that the farmer's safety record will be an object of envy.

Fig. 1—Campaund fracture of tibia and fibula is shawn at aperating table. This fracture accurred in a 5-year-old bay riding on the fender af a tractor which was driven by his 12-year-old brather.

During the five and one-half year period from July 1957 to November 1962, 2,413 patients were admitted to the Children's Orthopedic Service, University Hospitals, Madison, Wis. Of these, 16 patients were victims of farm accidents resulting in fractures and/or severe soft tissue injuries to the extremities. These patients comprised slightly less than 1 per cent of the total orthopedic admission, but more importantly, nearly 10 per cent of the fracture patients seen during this period. (This figure is derived from another tabulation which shows the fracture load on this service to be about seven per cent of the total admissions.) These injuries are not strictly fracture problems, but in all save 2 of the 16 there was significant bony injury.

Since the University of Wisconsin Hospital is primarily a referral hospital, our experience perhaps is not as significant numerically as other centers. However, when one considers that even one per cent of our children's orthopedic admissions were for treatment of farm injuries, it is obvious that agricultural mishaps are a definite concern. Since the more seriously injured patients are referred to this institution, our figures do not nearly represent the real magnitude of this problem.

In 1961 there were 93 fatal farm accidents throughout Wisconsin. Complete data on these accidents are not available, but it is known that 58 fatalities were caused by machinery accidents. Ninety per cent of the machinery accidents involved tractors, and more significantly, 18 persons killed by tractors were 24 years of age or younger.*

* These figures were supplied by Mr. Randall Swanson, Agriculture Engineering Division, College of Agriculture, University of Wisconsin, Madison.

Fig. 2—Anteroposterior x-ray view of Figure 1.

In 1946 Young and Ghormley[1] reviewed the problem of accidents on the farm and their experiences with these injuries at the Mayo Clinic, Rochester, Minn. Between 1935 and 1943 a yearly average of 64 farm accident victims of all ages were treated at their institution. Falls were the most common cause of accidents in their series, with machinery accidents next. It should be noted that one third of the patients injured by machines suffered traumatic amputations; and of the 575 patients reported in their series, 396 had fractures in addition to the 65 patients who sustained traumatic amputations. Reference is made in their paper to a 1945 Wisconsin survey which revealed that serious accidents occurred on one out of every nine farms.

Evans and co-workers[2,3] made an epidemiological study of farm injuries occurring in Dane County, Wisconsin, in 1958 and in 1960. They found an incidence of 1 nonfatal farm accident per month per 10,000 rural population. As in the present study, machines were most frequently responsible for injury (53.9%). When injuries were classified as to type of wound, the extremities were involved in 75.4 per cent of their cases, and fractures and amputations accounted for 40.6 per cent of the total. The purpose of the Evans study was to reach some understanding of the multiple etiologic factors occurring in farm accidents. From their investigation, it would appear that fatigue, haste, and carelessness were the chief causal factors of such accidents.

The more important fact to be considered is that these injuries can be virtually 100 per cent preventable, if indeed they are due largely to carelessness and indifference of the parents involved. It is a common practice to allow 10-year-old boys to drive tractors and operate other machinery, so it comes as no surprise that children are caught up frequently in farm machinery.

Nine patients in our series suffered injury when caught in drive belts, power take-offs, and loaders. These patients were all of an age where they would be expected to have some respect for machinery, and it thus appears that adequate safety shields were not utilized.

Another five cases (see illustrations) were rather obvious examples of poor judgment and irresponsibility on the part of parents. A child has no more reason to be around an

operating piece of farm equipment than around a punch press or a power saw operated by a father who is not a farmer. The best treatment in this group of patients is simple—prevention.

Two cases represented injury caused by falls. Falls are less prominent in this series than machinery accidents in contrast to the experience at the Mayo Clinic.

Considerable soft tissue destruction as well as bony injury was encountered. The paramount responsibility in the immediate care of these patients is preservation of life paralleling restoration of function of the injured limb. This entails (1) control of hemorrhage, (2) prevention of shock, and (3) prevention of infection, especially the anaerobic organisms of tetanus and gas gangrene. The first two of these three basic tenets are recognized almost universally. It is in the prevention of infection where therapeutic efforts sometimes are not vigorous enough. The basic fundamental requirement in this regard is early and adequate debridement. This means wide excision of all devitalized and contaminated tissue. Debridement must be carried down to actively bleeding tissue before an attempt is made to close the wound. This, of course, will require occasional sacrifice of considerable muscle mass and, indeed, may require amputation as an initial procedure. These requirements are not so stringent when skin is needed for coverage of a soft tissue defect, since devitalized skin which has no gross contamination may be used in much the same manner as a skin graft for temporary coverage. In many instances, delay in reaching a center where professional care is available will dictate against primary closure of the wound. Indeed, if the patient is not seen for six to eight hours after injury, it is prudent to not attempt primary closure but rather to allow healing by secondary intention.

Adjuvant measures to adequate debridement include antibiotics, tetanus and gas gangrene prophylaxis, and copious irrigation. Before debridement is begun, vigorous cleansing of the exposed tissue with germicidal soap and irrigation with saline solution is required. This is supplemented by routine surgical preparation of the remainder of the extremity. After debridement, copious amounts of saline solution should be used again to irrigate the wound before closure.

Fig. 3—Lateral x-ray view of Figure 1.

Fig. 4—Anteraposteriar x-ray view of tibia and fibula at time of admission. This case involved a 12-year-old bay whose leg became caught between a tractar and a tree. He sustained a clased fracture af the tibial plateau and praximal fibula and open, camminuted fractures af the distal tibia and fibula, alsa severe soft tissue and tendan laceratians.

Tetanus prophylaxis consists of booster doses of tetanus toxoid if the patient has been previously immunized in addition to 3,000 units of intramuscular tetanus antitoxin which will be required in many cases because of the obvious contamination. Preliminary skin testing is mandatory before use of tetanus antitoxin, after which the antitoxin may be administered.

The status of gas gangrene antitoxin is somewhat controversial. The U. S. Department of Defense no longer recommends the prophylactic use of trivalent antitoxin.[4] It is contended that this only delays the onset of the disease by 48 hours if the anaerobic conditions are such that such an event is encouraged. Gas antitoxin is not used routinely in this institution for prophylaxis, although it was used in some cases of this series. If clostridial infection occurs, prompt and vigorous treatment with intravenous antitoxin plus penicillin or other intravenous antibiotics in addition to reoperation and further debridement should suffice.

Prophylactic antibiotics are indicated in virtually all cases of soft tissue injury or compound fracture, but it must be emphasized that they are no substitute for surgical management. A combination of penicillin and streptomycin or a broad spectrum antibiotic such as parenteral tetracycline frequently can be used. We have used chloramphenicol initially in two recent cases with good results. However, caution must be used in the administration of this drug to avoid the development of blood dyscrasias.

Treatment of bony injuries should follow conservative lines in most instances and will be accomplished best by traction and casting, or both. Internal fixation is a temptation in these cases which should be resisted. Depending on the scope and success of initial management, a variable amount of reconstructive or adjustive treatment may be required. This would include fitting of braces and prostheses.

Summary and Comment. Sixteen cases of farm accidents occurring in children were evaluated with emphasis on the mechanism of injury, type of wound encountered, and general aspects of treatment. It is noted that proper control of this problem lies in preventative rather than therapeutic measures.

Fig. 5—Lateral x-ray view of Figure 4.

Fig. 6—Anteroposterior view of femur of a 3-year-old boy at time of admission. He stood on the draw bar of a tractor driven by his father, fell off, and the rear wheel ran over his thigh, resulting in a midshaft fracture of the femur.

It is questionable whether much can be accomplished toward prevention of farm injuries without more responsiveness of the farmer to safety measures. If the farmer divorced his children from his work around machines, as the factory worker does, a sharp decrease in accidents of this type would occur.

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REFERENCES

1. Young, H. H. and Ghormley, R. K.: Accidents on farm, J.A.M.A. 132:768–771 (Nov 30) 1946.
2. Walsh, L. G., Chackley, T. H. F. and Evans, A. S.: Nonfatal farm accidents; report of pilot study and review of literature, Wisconsin Med. J. 57:118–126 (Feb) 1958.
3. Cleary, J. P. et al.: Farm injuries in Dane County, Wisconsin; epidemiological study, Arch. Environ. Health 3:201–208 (Aug) 1961.
4. *Emergency War Surgery*, Department of Defense handbook, Washington; U. S. Government Printing Office, 1958, p. 149.

CLINICOPATHOLOGIC CONFERENCE

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Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: M. B. LLEWELLYN, M. D.

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Case Presentation.* *Dr. G. E. Gutmann:* Increasing exertional dyspnea developed in a 51-year-old white man in 1949. In March of that year he had a right spontaneous pneumothorax. In November, 1951, the diagnosis of hypertension of the lesser circulation was made at a veterans hospital. Chest fluoroscopy showed prominence of the right ventricular outflow tract and dilatation of the primary and secondary branches of the pulmonary artery.

The family history and past history, except for having been "gassed" in the military service in 1918, were negative.

He was examined in Janesville in December, 1951. He was well developed and well nourished, but he appeared breathless and the lips were cyanotic. His blood pressure was 130 systolic and 95 diastolic, and the pulse regular at 80. The lungs were clear and P-2 was accentuated. There were prominent varicosities of the lower extremities, without ankle edema.

In March, 1952, he experienced a transient right hemiplegia as well as auricular fibrillation. Regular rhythm was reestablished with the administration of quinidine. The electrocardiogram was consistent with the right ventricular strain pattern. Phlebothrombosis of the varicose veins in the legs and thighs later developed, and these subsequently remained cord-like in character and could be traced into the groins.

Because of a rising hematocrit reading and several nosebleeds, a number of phlebotomies were performed within the next few years. Right heart failure became obvious in June, 1953, and the neck veins were hugely distended even in the sitting position. Digitalis was administered to the patient. Episodes of right spontaneous pneumothorax recurred in June and October, 1955.

He was last hospitalized in November, 1956. Cyanosis then was extreme. He had lost 40 lb. in weight. The blood pressure was 90 systolic and 65 diastolic. The heart was markedly enlarged and an apical diastolic gallop was heard. P-2 was greater than A-2, but there were no murmurs. Right pleural effusion, hepatomegaly and ankle edema were evident. No clubbing of the nails was noted.

Laboratory examination showed a hematocrit reading of 45% and hemoglobin 11.3 Gm. per 100 ml. The red blood cell count was 5,250,000, the white blood cell count 8,250, with a normal differential. The sedimentation rate was 1 mm. At no time during his entire illness had the sedimentation rate been above 3 mm. Nonprotein nitrogen was 54 and the creatinine 5 mg. per 100 ml. A single urinalysis showed no albumin, specific gravity of 1.016, and 35 to 40 hyaline casts. The carbon dioxide combining power was 25.2 mEq. The sodium chloride was 111.7 mEq., and serum glutamic oxalopyruvic transaminase was 67 units. The electrocardiogram now showed low voltage of the QRS complexes, and continued evidence of right ventricular strain pattern and auricular fibrillation. The chest roentgenogram showed dilated pulmonary arteries, decreased vascularity of peripheral pulmonary parenchyma, and enlarged heart. He was bedridden for the next seven months. He had several bouts of pneumonia and abscesses of the lower extremities. He died suddenly at home on July 7, 1957.

Differential Diagnosis. *Dr. L. G. Kindschi:* This is the case of a man who spent the first 51 years of his life in apparent normal good health, and the last 8 years in dying miserably of the cumulative effects of cardiopulmonary disease.

The protocol describes a clear clinical picture of pulmonary hypertension with secondary cor pulmonale and terminal congestive heart failure. It also describes, but much less clearly, a rather vague type of throm-

* Mercy Hospital, Janesville.

botic disease which we must include in our attempt to picture the most likely sequence of events.

In general consideration, we shall begin with the premise that pulmonary hypertension is invariably due to increased resistance to the blood flow in the pulmonary circuit. Such resistance may be caused by parenchymal lung disease (either primary or secondary), by primary disease of the pulmonary arterial system, or by extrapulmonary disease.

Parenchymal lung disease can be rather quickly eliminated from serious consideration here, because there is no good evidence for it in either the protocol or the x-ray studies. Nevertheless, for the sake of completeness, I shall list the four most common categories of parenchymal pulmonary disease that can result in cor pulmonale and congestive failure.

(1) Idiopathic pulmonary emphysema, which is usually ascribed to a premature aging of parenchymal tissue with resulting loss of elasticity, is rarely a cause of cor pulmonale.

(2) Emphysema resulting from asthma, an inevitable result of this chronic disease; but unless it begins early in life, it rarely results in cor pulmonale. Under any circumstance, the primary disease would have been so obvious that it could not have been omitted from the protocol.

(3) Neoplastic disease, either primary or metastatic, might be so located as to cause external pressure upon any portion of the pulmonary arterial trunk. But again, one would expect to find objective evidence of the primary disease long before it would result in the development of cor pulmonale.

(4) Pulmonary fibrosis may result, from cumulative tissue reaction to injury. Such injury can be caused by infectious agents involving the bronchioles, the alveoli, or the connective tissue of the lung. It can also be caused by inflammatory granuloma such as Boeck's sarcoid, by injury from noxious substances such as silica, beryllium, or poison gas, or by repeated showers of tiny emboli from a remote part of the body. Under any of these circumstances, it is inconceivable that pulmonary fibrosis of sufficient degree to produce cor pulmonale would not have been demonstrated by x-ray studies.

Having thus eliminated parenchymal pulmonary disease from our consideration in this discussion, let us next turn to a consideration of intrinsic pulmonary artery disease as a cause of pulmonary hypertension and cor pulmonale. Unfortunately, this etiologic category is largely beyond the reach of the clinician's diagnostic arm, and sometimes it is even beyond the reach of the much longer diagnostic arm of the pathologist.

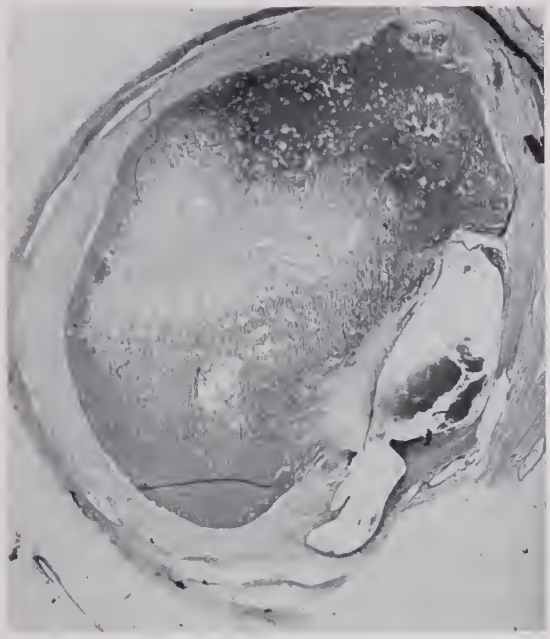

Fig. 1—Pulmonary artery branch shawing dilatatian and almost camplete abliteratian by an ald thrombus.

Intrinsic pulmonary artery disease can be listed in five categories.

(1) Congenital pulmonary artery stenosis is a rare condition that gives signs and symptoms early in life rather than in the middle years.

(2) Pulmonary artery arteriosclerosis, usually a part of the general aging process of the body, does not ordinarily result in pulmonary hypertension and cor pulmonale. But when it arises as a premature localized process in the younger age group, it can be of etiological significance. Unfortunately, I know of no way to make the clinical diagnosis before obvious damage has been done. In this way, the disease is comparable to the localized coronary artery sclerosis of youth. In both instances, the diagnosis is usually made at postmortem examination.

(3) Abnormal anastomotic bronchopulmonary channels have been described as a cause of pulmonary hypertension and cor pulmonale. But again, this is a diagnosis made by the pathologist rather than by the clinician.

Fig. 2—Raentgenogram shows dilated pulmonary arteries, decreased vascularity of peripheral pulmanary parenchyma and enlorged heart.

(4) Vasospastic disease in the pulmonary arteries, comparable to Reynaud's disease of the peripheral circulation, has been described. This can occasionally be suspected by the clinician, if a patient with pulmonary hypertension can obtain symptomatic relief with a vasodilator such as tolazoline hydrochloride (Priscoline).

(5) Pulmonary arteritis is the final possibility that I shall mention. This is a localized process comparable to the periarteritis or polyarteritis of the peripheral circulation. Again, the clinician is up against long odds in making the specific diagnosis, but it may be suspected, if the patient obtains symptomatic relief with steroid therapy.

Thus, in our reasoning up to this point, we have eliminated pulmonary disease as a cause of the pulmonary hypertension and cor pulmonale of our patient. Now we shall consider the extrapulmonary pathology that could conceivably bring about the sequence of events described in the protocol.

Extrapulmonary disease as a primary cause for pulmonary hypertension and cor pulmonale can be divided into two categories. The first includes congenital anomalies of the heart, the second involves those diseases capable of causing thrombosis and emboli.

In the case at hand we have no evidence of the type of congenital abnormality that can be distinguished by the clinician. But there is a type of anatomical defect, found only at autopsy, that is at least associated with the type of clinical entity we are discussing.

A recent paper from the Mayo Clinic describes 10 cases designated as idiopathic pulmonary hypertension. At autopsy, four of these cases were found to have a right-to-left shunt at the atrial level. This was unsuspected from the clinical examination, and unexplained as an etiological factor of the disease.

This is a most interesting observation, but any attempt to apply it to our particular problem, would, of course, be pure speculation.

So finally, our discussion narrows down to a consideration of those diseases capable of causing thrombosis and emboli. From the data at hand, this category would appear to offer the best etiological explanation, but it still requires rationalization.

If one had to choose a single etiology, it might logically be arteriosclerotic heart disease. This could produce the intermittent type of auricular fibrillation with thrombus formation in both atria. From the left would have come the cerebral thrombus of March, 1952, and from the right, the showers of tiny emboli to the lungs resulting in the spontaneous pneumothorax, the pulmonary hypertension, and the Ayerza-type syndrome.

There are two primary objections to this diagnosis. The first arises from the fact that the cerebrovascular episode was sufficiently transient to suggest vasospasm rather than embolic occlusion or hemorrhage. The second arises from the fact that there is no x-ray evidence of pulmonary infarction.

We shall, therefore, turn our attention to the final etiologic possibility, that of primary thrombotic disease.

Here again, we must rationalize two points. The first, again, is the lack of x-ray evidence of pulmonary infarction; the second is the absence of any specific information on the blood coagulation mechanism of our patient.

One of the most unusual features of this case was the severe phlebothrombosis of the lower extremities that occurred in April, 1952, about three years after the original symptoms, and five years prior to death. Conceivably, this might have resulted from the venous stases in the varicosities. But phlebothrombosis resulting from venous

stasis is almost always a spotty affair; rarely, if ever, a bilateral complete involvement. Unusual, too, is the implication that the phlebothrombosis stopped short of involving the intra-abdominal vessels.

Conceivably, too, phlebothrombosis of this degree might come as a result of polycythemia. But this I must reject, since the polycythemia of Ayerza's disease is a physiological response to tissue hypoxia and does not significantly alter the blood coagulation mechanisms; and the diagnosis of polycythemia rubra vera, which may involve the clotting mechanism, cannot be considered on the basis of available evidence.

Thus, at this point, many questions come to mind. What type of primary blood dyscrasia might have been present? What type of cryptic disease might have produced a secondary type of thrombotic disease? Might not the use of anticoagulants, even empirically, have helped this man, or at least arrested the progress of the disease?

Since the protocol offers us no help at all in answering these questions, I shall offer only a single speculative possibility, namely, a neoplasm of the pancreas or duodenum. This is an intriguing possibility, since statistically a carcinoma in this area of the body is accompanied 16 per cent of the time by some form of thrombotic disease.

Obviously, this idea does not fit well into the present problem. Except for the history of duodenal ulcer, the finding of an elevated serum transaminase, and the progressive weight loss, there is no information pointing to such a possibility. In fact, there is much that points away from it. The eight-year period of illness, the general clinical picture, and the available laboratory data, all weigh against the diagnosis of a primary neoplasm of the pancreas or duodenum. But, by the same token, the same information fails to provide us with a more obvious specific cause for the thrombotic phenomenon.

In summary, then, I venture the following diagnosis:

(1) Pulmonary hypertension (secondary) with cor pulmonale and irreversible congestive heart failure.
(2) Primary arteriosclerotic heart disease.
(3) Thrombotic disease of undetermined type, possibly primary, possibly secondary to a neoplasm of the pancreas or duodenum.

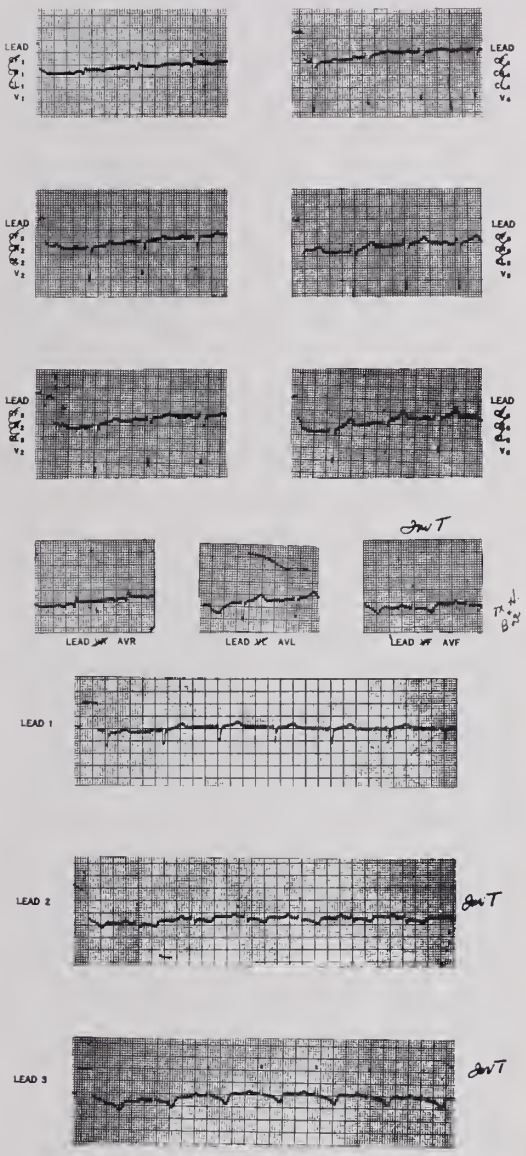

Fig. 3—Electrocardiographic changes consistent with right ventricular strain pattern.

Pathological Discussion. *Dr. M. B. Llewellyn:* At autopsy the heart weighed 600 Gm. The enlargement was due to tremendous dilatation and hypertrophy of the right ventricle and atrium. The estimated dilatation was about three times normal and the right ventricular wall measured up to 1 cm. in thickness, the normal being 2 or 3 mm. The foramen ovale was closed and there were no congenital anomalies and no mural thrombi. The heart valves and the coronary arteries were normal.

The left pulmonary artery was dilated, and beginning 2.5 cm. above the pulmonary valve was lined by relatively dry, firm, tan, homogeneous thrombus measuring up to 2.5 cm. in thickness. The thrombus was densely adherent to the intima and extended into the larger branches supplying the upper lobe to practically occlude them. The branches supplying the left lower lobe did not contain thrombi. The right pulmonary artery measured 3.5 cm. in diameter and was almost completely occluded by a similar thrombus. The first 3 or 4 cm. of the branches supplying all lobes of the right lung were dilated and almost completely occluded by thrombus. The intima of the pulmonary artery not containing thrombi was smooth with no appreciable atherosclerosis.

The lungs proper showed no evidence of old or recent infarction. Because of their partially collapsed state, emphysema was not recognized grossly.

Approximately 300 cases of chronic thrombosis of the major pulmonary arteries have been reported. Dr. William S. Middleton reported 53 cases in 1943. Many of the reported cases have been secondary to and often overshadowed by some other disease. Pulmonary artery thrombosis has occurred in congenital heart disease such as pulmonary stenosis, tetralogy of Fallot, and septal defects and in acquired cardiovascular disease such as mitral stenosis, myocardial infarction, syphilitic and other types of arteritis; or it has been secondary to contiguous disease such as pulmonary tuberculosis, silicosis, metastatic or bronchogenic carcinoma. However, it is primary thrombosis of the pulmonary arteries that concerns us.

Primary pulmonary artery thrombosis may occur as the result of (1) organization of pulmonary emboli, (2) in situ thrombosis or arteriosclerotic plaques, or (3) thrombosis following chest trauma. In our case there was no history of trauma to the chest, so we can dismiss that as a cause.

Since 1946, Castleman and Bland have been reporting chronic cor pulmonale due to unrecognized multiple small emboli to the lungs. All of their 12 cases have shown evidence of organizing emboli in the small peripheral branches of the pulmonary arteries of both lungs on microscopic examination. In 5 of the 12 cases the large branches of the pulmonary artery have been occluded by thrombi in a manner not unlike our case. However, we were unable to find evidence of embolism or changes in the small arteries of the lungs so we cannot ascribe the cause advocated by them to our case.

Several cases of major pulmonary artery thrombosis produced by emboli obstructing large branches of the pulmonary artery have been reported. In these cases the patients usually have had a history of one or more attacks of dyspnea, hemoptysis, and chest pain. When a nonfatal embolus lodges in a pulmonary artery, organization soon follows. A recent embolus is easy to recognize as such at autopsy, but by the time cor pulmonale develops months or years later, the embolus has lost its characteristics and is indistinguishable from an in situ thrombus. Therefore to incriminate a large embolus, one must depend upon the history, and in our case we have no history of an embolic attack.

We are left with an in situ or autochthonous thrombosis. In the microscopic section we see a small arteriosclerotic plaque beneath the thrombus, and this is the only positive finding that supports the in situ thrombosis hypothesis. But the fact that the thrombus overlies an atheromatous plaque is not a guarantee that the thrombus is autochthonous because atherosclerosis can develop proximal to an obstruction and then be covered by a propagating thrombus. However, I have given my reasons why I do not believe the thrombus in our case to be embolic in origin. I favor in situ thrombosis of the large pulmonary arteries as the underlying cause of the cor pulmonale in this case.

Clinical Correlation. *Doctor Llewellyn:* In 1949 the patient gradually developed dyspnea which increased in severity and later was treated by digitalis without success. In 1951 chest x-ray films showed prominent pulmonary trunks with clear lung fields and the diagnosis of pulmonary hypertension was made. The thrombotic obstruction of the pulmonary arteries undoubtedly goes back at least to 1951, and probably back to 1949. Dyspnea is the most frequent symptom encountered in this condition and was present in 90 per cent of the cases reported by Middleton. Also, these patients characteristically do not respond to the usual therapy for cardiac failure. The x-ray films of the chest show a classic picture of enlargement of the main pulmonary arteries, with decreased vascularity beyond due to the block in the pulmonary circulation.

Syncope and mental confusion are fairly common symptoms in this condition and are due to cerebral anoxia but they were not exhibited by our patient. However, in 1952 he suffered a left hemiplegia which cleared in a day or so following a right stellate ganglion block. The transient hemiplegia may have been caused by cerebral ischemia due to his low cardiac output, and the unusually good response to a stellate ganglion block may have been a coincidence. However, thrombosis of a carotid artery cannot be excluded.

Also in 1952 he developed phlebothrombosis of both lower extremities. At this time he was having right ventricular failure which would predispose to venous thrombosis. Cyanosis due to incomplete oxygenation of the blood was becoming more and more pronounced. A moderate polycythemia was noted, and this is present in a definite proportion of these cases.

In 1953 he had several hemoptyses. X-ray films showed no evidence of pulmonary infarcts during this time and the hemoptyses are best explained on the basis of rupture of the anastomoses in collateral circulation which develop between the bronchial and pulmonary arteries in cases of pulmonary artery obstruction.

The entire syndrome of the right side heart failure including peripheral edema, enlargement of the liver, and ascites is related directly and solely to the occlusion of the pulmonary arteries which obstructed the flow of blood from the right ventricle. It is also noted that during the years in which the patient was under observation his blood pressure gradually fell from 130/95 to 80/60. It is characteristic for these patients to have low blood pressure and a small pulse pressure.

Final Diagnoses. Chronic cor pulmonale due to chronic pulmonary artery thrombosis, pulmonary emphysema, cardiac cirrhosis, splenomegaly, ascites, bilateral hydrothorax, hydropericardium, dependent edema, bilateral pleural adhesions, cholelithiasis, diverticula of duodenum, and prostatic hypertrophy comprised the diagnosis made.

Summary. A case of thrombotic occlusion of the large pulmonary arteries which occurred insidiously and produced progressive right ventricular failure was presented. Because of recent and continuing advances in cardiovascular surgery and anticoagulant therapy, correct diagnoses in such cases will become more and more important in the future.

REFERENCES

1. Shephard, J. T., et al: Clinical, physiological and pathological considerations in patients with idiopathic pulmonary hypertension, Brit. Heart J. 19: 70–82 (Jan) 1957.
2. Hoerr, S. O. and Harper, J. R.: Clinical notes on peripheral thrombophlebitis: its occurrence as a presenting symptom in malignant disease of pancreas, biliary tract, or duodenum, J.A.M.A. 164:2033–2034 (Aug 31) 1957.
3. Hollister, L. E. and Cull, V. L.: Syndrome of chronic thrombosis of the major pulmonary arteries, Am. J. Med. 21:312–320 (Aug) 1956.
4. Castleman, B. and Bland, E. F.: Organized emboli of the tertiary pulmonary arteries; unusual cause of cor pulmonale, Arch. Path. 42:581–589 (Dec) 1946.
5. Kernen, J. A., O'Neal, R. M. and Edwards, D. L.: Pulmonary arteriosclerosis and thromboembolism in chronic pulmonary emphysema, Arch. Path. 65:471–478 (May) 1958.
6. Ball, K. P., Goodwin, J. F. and Hanson, C. V.: Massive thrombotic occlusion of the large pulmonary arteries, Circulation 14:766–783 (Nov) 1956.
7. Davisom, P. H., Armitage, G. H. and McIlveen: Chronic cor pulmonale due to silent pulmonary embolism, Lancet 2:224–226 (Aug 4) 1956.
8. Brewer, W. R., Thomas, W. A., Castleman, B. and Bland, E. F.: Unrecognized emboli to the lungs with subsequent cor pulmonale, New Eng. J. Med. 249: 919–926 (Dec) 1953.

ABSOLUTE SAFETY NOT GUARANTEED

By its enactment of the Kefauver-Harris Act last year, Congress placed far-reaching and fearsome new responsibilities on the Food and Drug Administration. Now, we believe that Congress should follow through and provide FDA with the resources it needs to do its new job wisely and well. In the words of John T. Connor, President of Merck & Company —"It would be a senseless tragedy if this nation forfeited its leadership in drug progress, not for lack of discoveries, but because a regulatory agency could not keep pace." . . . But however well the FDA is armed by Congress with human and material resources, none of us should lose sight of the fact that the pathways of scientific research and development are uncertain ones at best, and that no rule or regulation or law can guarantee absolute safety whether in outer space or in the pharmaceutical laboratory or the hospital clinic.—THEODORE G. KLUMPP, M.D., President, Winthrop Laboratories, to Senate Appropriations Subcommittee, April 4, 1963.

CASE REPORT

Secondary Surgery of a Congenital Esophageal Atresia with Tracheo-Esophageal Fistula

By WILLIAM M. STOLL, M. D., Green Bay, Wisconsin

■ THE CASE HISTORY presented is a follow-up of the first successful case of primary anastomosis for esophageal atresia with tracheo-esophageal fistula, with initial surgery in 1941.

Case Report. A 20-year-old white woman was seen in consultation in June 1961. The history revealed that this patient had been operated on by Dr. Cameron Haight[1] of the University Hospitals, Ann Arbor, Mich., on March 15, 1941, 12 days after birth. The surgery consisted of a left retropleural approach with primary anastomosis of the esophageal atresia and division of the tracheo-esophageal fistula. The only antimicrobial agent used postoperatively was sulfathiazole, administered rectally. An esophago-cutaneous fistula developed which healed by the twentieth postoperative day but resulted in a stricture at the site of the primary esophageal anastomosis. This had necessitated esophageal dilatations since 1941.

The patient had been on a semi-liquid diet her entire life. Her most recent swallowing difficulty had occurred the night before admission when she had attempted to eat some fine meat particles.

A barium swallow at the time of admission revealed a complete obstruction of the upper thoracic esophagus with proximal dilatation. Esophagoscopy demonstrated a dilated proximal pouch which contained food particles. After the pouch had been cleansed, a 3-mm. lumen could be visualized at the outlet. This strictured lumen was then explored with the smallest of dilators, but dilatation could not be performed because of a tight stricture which bled upon attempted dilatation. Further attempts to dilate the stricture seemed inadvisable.

A barium swallow the next day revealed the dilated proximal pouch and the 3-mm. strictured segment extending approximately 1.5 cm. distally, beyond which appeared to be a normal esophageal lumen.

The patient returned in two weeks for resectional surgery. Resection of the strictured esophageal segment was carried out through a right transpleural approach. The patient began a liquid diet on the fourth postoperative day and was discharged on the tenth postoperative day on a soft diet which was gradually increased to a normal diet. Predischarge barium swallow x-rays revealed a normal esophageal lumen at the surgical site. A follow-up barium swallow several weeks later revealed a normal lumen. She has since enjoyed the pleasures of a normal diet.

Summary. This case describes the long-term follow-up, with subsequent esophageal resectional surgery, of the first case of recovery following primary anastomosis for esophageal atresia with tracheo-esophageal fistula. This patient had been operated by Dr. Cameron Haight of Ann Arbor, Mich., in 1941. In 1961 she had a resection of her long-standing esophageal stricture, performed by the author. She had an uneventful recovery and for the first time enjoyed a normal diet. This case is presented primarily because of its historical interest. The author wishes the readers to be aware of the great work in this field of thoracic surgery which has been pioneered by Doctor Haight.

238 Little Road.

* From St. Vincent Hospital, Green Bay.

REFERENCE

1. Haight, C.: Congenital atresia of esophagus; some observations on esophageal atresias and tracheoesophageal fistulas of congenital origin, J. Thoracic Surg. 34:141–172 (Aug) 1957.

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

Chemotherapy of Herpes Simplex Virus and Vaccinia Virus

By HAROLD F. HARDMAN, Ph. D., M. D., Milwaukee, Wisconsin

■ PRIMARY infection by herpes simplex virus is common in man and it appears that the virus may remain within the tissues for the duration of the lifetime of the host in spite of the development of antibody. The primary infection with this virus occurs most often in the early years of life and involves approximately 80 per cent of the population. Only a small percentage of these infections become clinically recognizable; however, the virus remains within the host resulting in recurrent signs and symptoms of infection at irregular time intervals. A primary infection can be diagnosed on the basis that the host lacks circulating antibody to the virus.

Acute vesicular gingivostomatitis, as well as vulvovaginitis, meningoencephalitis and a disseminated visceral form occurring chiefly in premature and newborn infants, may be observed. Within 4 to 8 days after infection neutralizing antibody appears and reaches a maximum titer about the fourteenth day postinfection. The titer may remain elevated for a variable time and fluctuating antibody levels are suggestive of multiple infection. As antibody is produced, the virus establishes a tolerant relationship with its host and appears to remain in a dormant state in the body tissues.

Recurrences of herpes simplex symptoms are probably due to alterations in the resistance of the host and these changes in resistance can be precipitated by multiple circumstances. These include fever, upper respiratory infection, emotional stress, menstruation, overexposure to the rays of the sun, nerve injury, and gastrointestinal allergy. Although neutralizing antibody may be present in very high titer at the time of an attack, it does not appear able to prevent the attack.

The most common form of recurrent herpes is the "fever blister" or "cold sore," a vesicular crusting lesion appearing on the skin near the nose and at the margin of the lips. Similar lesions may appear anywhere on the skin or special lesions may occur in the eye.

Herpes simplex infection of the cornea, unlike infection of the skin, tends to become chronic and may progress to form opaque and blinding scars. In many cases a permanent diminution of vision is the result of this infection. Many ophthalmologists consider herpes simplex keratitis as the most important corneal disease in the United States which produces loss of vision.

The diagnosis of a classic case of early herpetic keratitis may be made largely on the basis of a branched dendritic ulcer involving the corneal epithelium. Therapy of herpes simplex keratitis has consisted primarily of the removal of infected tissue. When only the corneal epithelium is involved by the infection, removal of the area of ulcer appears to accelerate healing. The removal of infected tissue may be facilitated by the use of denaturing agents such as iodine or silver nitrate, by mechanical curettage, or by the use of enzymes such as chymotrypsin. Epithelial debridement does not always prevent the progression of the disease to the stroma, nor is it effective in

treating corneal disease once the deeper layers of the cornea are involved. In addition, there is evidence that some denaturing agents employed for chemical curettage may cause further loss of vision by precipitating stromal protein and causing additional opacification.

Chemotherapy of Herpes Simplex Keratitis. In 1962 Dr. Herbert E. Kaufman reported that the chemical agent 5-iodo-2'-deoxyuridine could cure herpes simplex keratitis. This work has been confirmed in numerous other laboratories and three commercial preparations are now available as ophthalmic solutions. The generic name of this new chemotherapeutic agent is idoxuridine. It can be obtained from Smith Kline and French Labs., Alcon Labs., Inc., or Allergan Pharmaceuticals, Inc.

Preliminary studies indicate that idoxuridine may also be effective in the treatment of facial and genital lesions produced by the herpes simplex virus, although the drug has not been cleared by the Food and Drug Administration for these latter uses.

Biochemical studies suggest that idoxuridine does not kill the herpes simplex virus but inhibits its multiplication. The drug has a chemical configuration similar to that of thymidine, an essential chemical component for viral multiplication. It appears that idoxuridine competes with thymidine for its place in the herpes simplex virus. When this occurs the viral infection becomes self-limiting since viral replication is inhibited.

The concept that idoxuridine is incorporated into the DNA of the herpes simplex virus may account for the reported ability of the drug to reduce the recurrence rate of this viral infection. The presence of idoxuridine in the DNA of the herpes simplex virus provides a modified virus which cannot damage host cells and serves to replace the infective virus. The continued presence of this modified virus may compete with the infective form of the herpes simplex virus for tissue receptors and thereby reduce the rate of recurrent infections.

Prior to the initial reports by Kaufman relating to the value of idoxuridine in the treatment of herpes simplex keratitis no specific agent had been reported for the therapy of any "true" virus disease. Attempts to control virus disease have included the use of antibody, interferon, antimetabolites, and other chemical agents. A number of agents have been found which could prevent infection when given at the time of inoculation or as long as 24 hours after inoculation. None of these substances could cure or significantly improve the viral diseases once they were clinically established. The discovery that idoxuridine was effective in the treatment of keratitis caused by the herpes simplex virus marked the first specific treatment of any "true" virus disease.

Prophylactic Chemotherapy for the Vaccinia Virus. In September 1963, Bauer and coworkers reported that N-methylisatin beta thiosemicarbazone (Marboran) was an effective drug in the prophylactic treatment of human beings who had been exposed to smallpox infections. These studies were carried out among the house contacts of smallpox patients admitted to the Infectious Diseases Hospital in Madras, India.

The treatment of the smallpox contacts was started one day after admission of the primary case to the hospital. The contacts were observed for a period of 16 days and during this time three mild cases of smallpox occurred among 1,101 treated contacts. By contrast there were 78 cases of smallpox with 12 deaths in the control group of 1,126 untreated contacts. The drug exerted its prophylactic effect regardless of the vaccination status of the contacts and was much more effective than vaccination or revaccination in protecting persons who had been in contact with smallpox infection. The only side effects observed were some nausea and vomiting.

Conclusions. Two major advances in the chemotherapy of viral diseases have been reviewed. In the case of idoxuridine we have a highly specific chemical agent which can effectively treat an established viral infection. The second agent, Marboran, is indicated for prophylactic treatment of persons exposed to smallpox infection.

It appears to me that we are on the threshold of major advances in the therapy of viral diseases. These advances may rival the antibiotic era in importance. The high degree of specificity observed in the effect of chemotherapeutic agents upon viruses suggests that we may be able to avoid some of the problems which were inherent to the wide spectrum antibiotics. These problems

include the development of drug resistant bacterial strains and the alteration of normal bacterial flora in the host.

GENERAL REFERENCES

Kaufman, H. E.: Clinical cure of herpes simplex keratitis by 5-iodo-2'-deoxyuridine, Proc. Soc. Exp. Bio., N. Y. 109:251-252, 1962.

Howard, G. M. and Kaufman, H. E.: Herpes simplex keratitis, Arch. Ophthal. 67:373-387, 1962.

Kaufman, H. E., Nesburn, A. B. and Maloney, E. D.: IDU therapy of herpes simplex, Arch. Ophthal. 67: 583-591, 1962.

Kaufman, H. E., Martola, E.-L. and Dohlman, C.: Use of 5-iodo-2'-deoxyuridine (IDU) in treatment of herpes simplex keratitis, Arch. Ophthal. 68:235-239, 1962.

Kaufman, H. E., Maloney, E. D. and Nesburn, A. B.: Comparison of specific antiviral agents in herpes simplex keratitis, Invest. Ophth. 1:686–692, 1962.

Bauer, D. J., St. Vincent, L., Kempe, C. H. and Downie, A. W.: Prophylactic treatment of smallpox contacts with N-methylisatin β-thiosemicarbazone, Lancet ii: 494-496 (Sept 7) 1963.

WANT GOVERNMENT TO CONSIDER WISCONSIN FOR SITE OF NEW HEALTH CENTER FACILITY

A Wisconsin representative in Congress, Henry S. Reuss, Milwaukee democrat, in late September urged Welfare Secretary Celebreeze to again consider Wisconsin, particularly the Milwaukee and Madison areas, as a "uniquely suitable" site for a new 78 million dollar federal environmental health center.

Mr. Reuss has also urged Marquette University, the University of Wisconsin, and the UW–Milwaukee to draft a coordinated plan for locating the health center in Wisconsin. The plan would be presented to Mr. Celebreeze.

The health center would employ between 5,000 and 6,000 persons, many in a variety of scientific fields. Its annual payroll would exceed 50 million dollars.

The center's scientists would conduct research in air and water pollution, radiological, industrial noise, milk sanitation, and pesticides.

The House appropriations committee rejected a Beltsville, Md., site, expressing doubts about the advisability of locating the center in the Washington area; hence, the emphasis again on Wisconsin.

UNIVERSITY OF WISCONSIN CORRESPONDENCE INSTRUCTION PROGRAM

"Legal Problems in the Practice of Medicine"

For physicians interested in the law as it affects them in their day-to-day work, The University of Wisconsin Correspondence Instruction Program now offers a home study course, "Legal Problems in the Practice of Medicine."

Endorsed by the American Medical Association, the course is a joint project of the Association's Law Department and the University of Wisconsin, developed to provide the physician with an opportunity to acquire some knowledge of the principles and operation of American law as well as the interrelationships of law and medicine.

Aims of the course are to inform physicians about possible legal problems and procedures which might arise in their practice, to acquaint them with specific statutes and court decisions affecting and regulating the practice of medicine, and to assist them in understanding the role of legislatures, administrative bodies, courts and attorneys in relation to medical practices. Hope is that the course will enable physicians to avoid situations which might give rise to medical professional liability actions against them and to prepare them to recognize legal situations that may require the assistance of an attorney.

Tuition for the course is $32.50 for residents of Wisconsin, $37.50 for non-residents. Texts and selected readings for use in the course are purchased by the student. In line with the established practice of The University of Wisconsin Extension Division, assignments will be completed and mailed to the instructor for evaluation and comment. Assignments may be completed and submitted by the registrant at his convenience, though the course must be completed within one year.

Interested physicians may write The Correspondence Instruction Program, 105 Extension Building, Madison, Wisconsin 53706 for further information.

THE PRESIDENT'S PAGE . . .

IS THE WISCONSIN STATE MEDICAL SOCIETY THE "CONSCIENCE OF MEDICINE" IN OUR STATE?

■ FOR SOME TIME I have been sending medical literature to a physician member of the Philippine Medical Association (PMA). He recently forwarded a 12-page pamphlet which is sent to every physician applicant before he becomes a member.

"Foreword.

Dear Brother Physician,

The rank and file of physician members of the Philippine Medical Association will be greatly honored to have you as a member. Before you do so, however, we would want you to go through these pages and read for yourself what the Philippine Medical Association stands for, what it has done for physicians of the Philippines and for the whole country.

The Philippine Medical Association stands for *you* and with your noble dreams and aspirations as a physician, the *organization is the conscience of the whole medical profession in this country,* by joining the Association you can share in the benefit from the organization and we do hope you can chip in our goal of leadership in the upliftment of our people.

COME JOIN WE AWAIT YOU

Sincerely yours,
The Executive Council
Philippine Medical Association"

PMA was founded in 1903, with sincere and determined pursuance of its goal in becoming the guiding spirit in molding the health policies and programs of its nation.

The achievements of the society have been remarkable. It recommended establishment of the medical school, legislation for the general use of unpolished rice to combat beri-beri, and to extend better care and provide training facilities for physicians for provincial and insular hospitals.

In 1922, it organized the Committee for Cancer Control and legislated acts for control and prevention of communicable diseases such as smallpox and cholera, and in the treatment of leprosy. It brought about changes in the medical act to raise the standards of practice and medical education.

continued on page 421

In 1927, it created the National Research Council and the Committee on Drugs and Patent Medicines to protect the public and assist the physicians, created the Department of Health, and adopted the Principles of Ethics.

In 1953, September 15 was declared *Philippine Medicine Day.* This medicine day is now being religiously observed by the PMA to emphasize to the people the value of health as a patrimony of the nation.

The activities of the society are divided into three main categories. For the individual physician they offer clinical seminars, united district assemblies, annual meetings, and other means of continuing education.

One unique service is a system of "study grants"—a one-week postgraduate course—and the *grantees are paid* daily for taking this course. The programs are especially prepared according to the expressed needs of the rural and private practitioners.

The second category covers "your medical practice" in which private medical practice is encouraged and protected by PMA in holding inviolate the confidence and intimacy of patient-physician relationship through the code of ethics. It works vigilantly to prevent the inroads of socialized medicine, and is ever vigilant in legislation that affects the practice of medicine. The standard of practice is held elevated by the Board of Examiners and the Board of Medical Education. It is responsive to job placement locally and abroad. It encourages and assists its members in all community activities—for improved public relations and help fight the competitors—the quacks. Assistance is given in court litigation.

The association is very solicitous in providing not only for its physician members but also to their families. They have set up a *mutual aid trust emergency fund* and *disability* plan. For a "meager sum of P27.00," this fund guarantees a sizable amount of assistance annually. They state that "this is the cheapest insurance in the world."

The third category provides additional benefits—monthly PMA news, hospital accreditation, inspection teams to determine if the medical schools maintain at least the minimum standards of an accredited medical institution. The Committee on Legislation continuously prepares legislation and amendments that govern their practice and protect their rights as physicians.

"The Committee on Ethics sets your dignity as a physician—it protects your ethical practice by setting the norms of conduct of the physician and protects you from the inroads of unethical practices by other physicians."

They are building up a more complete medical library.

Fees—each component medical society has its own rate of membership fees. Out of this membership fee, P11.00 goes to the mother association and P3.00 for the PMA Journal and P8.00 goes for operating costs. This does not, of course, include subscription to the Mutual Aid Trust and Emergency Fund.

The membership fees for the 62 component societies range from P15.00 to P26.00.

W. J. Egan M.D.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

OCTOBER 1963
Vol. 62 No. 10

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Fair Trade Time Again

■ IN THE SEPTEMBER, 1959, issue of the *Wisconsin Medical Journal*, editorial alarm was sounded over the advocacy of "Fair Trade" by our friends in the pharmaceutical profession. Now the National Association of Retail Druggists, at the head of about 70 other retailer organizations, is once again putting the pressure on the Congress to pass a fair trade bill. The proposed legislation would enable manufacturers to set minimum retail prices on brand-name drugs, appliances, and other products, and take legal action against any retailer who sold the merchandise for less.

The last time the retailer trade groups went to Washington with this kind of price-fixing legislation, they got the back of the congressional hand. This time, they're presenting the same dummy dressed up in a new suit of clothes. They are calling it a "quality stabilization" bill, but its price-fixing, and consequently price-increasing intention is undisguised.

The retailers claim the purpose of the bill is to allow the smaller store-keeper to compete with the large chains and the discount houses who, for one reason or another, find it possible to sell merchandise with a lower margin of profit. The supporters of fair trade legislation claim that the "social benefit" of maintaining small stores in business is worth the increase in price that will inevitably follow from passage of such legislation.

Some states now have fair-trade laws on the books. In these states, according to the Justice Department, name-brand items cost somewhere between 19 and 27 per cent higher than they do in areas where prices are subject to free competition. This means that the lower income families, who can't order by mail from out-of-state or must buy on credit, must be penalized by paying higher prices for some types of merchandise.

The proposed legislation is full of irony. It seeks to validate the manufacturer's predetermined price at a time when the Federal Trade Commission, which was established to act as a watchdog for the consumers' interests, is fighting a valiant battle to eradicate this practice. It is introduced by the very groups that have been most vocal in their accu-

sations of "socialism" when Washington applied regulation to their businesses.

Aside from the questionable argument that guaranteeing a rate of profit will enable an uneconomic enterprise to operate successfully, the case advanced by the fair-trade advocates who seek to put a floor under prices is just as vacuous as that of the price-fixers who wanted to put a ceiling on all prices during and just after World War II. There was justification for government price-fixing in periods of commodity shortages. But there is no valid reason in the public interest why the government should eliminate price competition in normal times.

Once it is established, the principle of using the authority of the federal government to enforce the rules of private competition will effectly outflank any future resistance to the extension of federal management into every area of our lives. Freedom of enterprise will have been killed—with the retailers trade groups prominent in the firing squad.

The medical profession has long opposed the intrusion of bureaucracy in the administration of the health care of the nation. We can hardly be indifferent now when a group invites the federal government to intervene in private enterprise—especially to set up a private advantage against the public welfare. We hope the pharmacists, who bear the same stake in the continuation of the American system as we do, will look over the tops of their ledger books and blow the whistle on their trade organization before it finally opens a Pandora's box of federal mish-mash.

—D. N. G.

A Strong Ally

AS MEDICAL procedures become more and more complex, doctors everywhere place greater dependence on their medical assistants. If the quality of medical care is to remain excellent, it is important that the ladies who work with us as assistants be well educated in their duties, conscientious in their assumption of responsibility and beyond reproach in their character.

In our state, the organization that sets the standards of education and the requirements of qualification for medical aide in the doctor's office is the Wisconsin State Medical Assistants Society. It operates to upgrade the position of medical assistant and to promote the professional stature of those engaged in the work. The State Medical Society appoints three physician members and two staff members as advisors to the group. Dr. Dan E. Dorchester of Sturgeon Bay is on the National Board of Advisors of the group's parent organization, and October 9, 1963, found him at the annual convention in Miami Beach, Florida, to honor the retiring president, Wisconsin's own Alice Budny.

The Medical Assistants society does a great service to the cause of health care in Wisconsin, and it, in turn, deserves the cooperation and support of each individual doctor. By aiding them, we are helping them to assist us more effectively.—D. N. G.

$300,000 GRANT TO MARQUETTE

A $300,000 grant from the Allen–Bradley Foundation, Milwaukee, to establish a department of occupational and environmental medicine was accepted in September by the Marquette University School of Medicine's board of directors.

Teaching and research in industrial health fields will be expanded under terms of the grant. Management of employe health programs and rehabilitation of medically disabled workers will be emphasized.

Dr. John S. Hirschboeck, dean, said the new department could provide an opportunity for medical students to prepare for full or part-time careers as physicians in industry.

UW GRANTED MERCK MEMORIAL LOAN FUNDS FOR INTERNS AND RESIDENTS

The University of Wisconsin is among an additional 10 medical schools which have been given George W. Merck Memorial Loan Funds for Interns and Residents, according to an announcement by Edward Reynolds, president of The Merck Company Foundation. Inclusion of these additional schools increases the total value of the Funds from $400,000 to more than $600,000.

Established in 1959 to honor the late president and chairman of the board of Merck & Co., Inc., the George W. Merck Memorial Loan Funds are designed "to encourage deserving interns and residents to seek the best possible postgraduate training."

The 19 schools at which the George W. Merck Memorial Loan Funds were initiated were chosen on the basis of close personal friendships of Mr. Merck with members of the faculties of these schools. The 10 additional schools were selected, among other reasons, for the record of their graduates in academic medicine.

NEW STUDENT LOAN PROGRAM APPROVED BY FEDERAL GOVERNMENT

The federal government has a new $235 million program that will provide financial aid for construction of medical schools and loans to medical students.

The Senate in mid-September passed by a vote of 71 to 9 the Administration's medical education bill in the identical form that the House had approved it earlier. President Kennedy promptly signed it into law.

Before approving the bill, the Senate rejected by a 43-to-39 vote an amendment that would have forgiven part of the loan to a student if, after graduation, he practiced in an area where there was a shortage of doctors. The Senate also voted down, 63 to 18, a proposal that would have knocked out loans to students.

The bill authorizes a three-year, $175 million matching grant program for the construction, replacement, or rehabilitation of accredited public or nonprofit teaching facilities for the training of physicians, dentists, pharmacists, optometrists, podiatrists, nurses, or professional public health personnel. A grant can not exceed 66⅔ per cent of the cost of construction for new schools or new facilities at existing schools.

The new law authorizes a loan program, patterned after the National Defense Education Act, for full-time students in schools of medicine, dentistry or osteopathy.

Loans can not exceed $2,000 for a student in any academic year. Schools will be required to give preference to first-year students in the school year 1963–64. Loans will be repayable over a ten-year period which would begin three years after the student ceases to pursue a fulltime course of study.

The unpaid balance of a loan will bear 3% interest per annum or the going Federal rate for obligations having a 15 year or more maturity, whichever is higher. Loans will be made without security or endorsement, except in the case of a minor where the note would not create a binding obligation.

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin.

Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills.

In any event, all contributions to the Foundation are deductible for income tax purposes.

Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.

STATE MEDICAL SOCIETY FORMS GROUP TO ASSIST IN KERR–MILLS ADMINISTRATION

Organization of the Wisconsin Health Service (WHS), which would be prepared to help administer the new Wisconsin Kerr–Mills program of medical assistance to the aged, has been announced by the State Medical Society of Wisconsin.

The new program, known as the Health Assistance Payments Act (HAPA), is scheduled to begin July 1, 1964. It calls for administration of benefits by physicians or hospital service corporation or a private insurance company. The Wisconsin Health Service would be eligible for selection, which will be made by the Department of Public Welfare.

Named to direct WHS are Drs. D. N. Goldstein, Kenosha; E. J. Nordby, Madison; P. B. Mason, Sheboygan; Charles Benkendorf, Green Bay; D. A. Jeffries, Shawano; W. T. Casper, Milwaukee; H. W. Carey, Lancaster; and E. M. Dessloch, Prairie du Chien.

Under HAPA, "near needy" persons over age 65 who meet the specific requirements would receive financial assistance in paying for health care costs. It is financed partly by federal funds and partly by state funds and is expected to cover some 175,000 persons. Cost of the program, when in full operation, is estimated at $10,000,000 per year.

To be eligible, persons must give a sworn statement that they are at least 65 years old, citizens, are not receiving old age assistance, and do not have personal assets of more than $5,500 if single or $9,000 if married, and do have an annual income of less than $1,800 if single or $2,700 if married.

The State Department of Public Welfare will be responsible for general supervision of the plan, and for establishing eligibility of beneficiaries; the insurance organization, such as Wisconsin Health Service, will contract with the state to pay the benefits.

the wisconsin medical journal

VOLUME 62/NUMBER 11 NOVEMBER 1963

Co-Existent Cystosarcoma Phyllodes and Scirrhous Adenocarcinoma of the Breast

By W. G. RICHARDS, M. D. and R. W. WAY, M. D.

Beaver Dam, Wisconsin

■ CYSTOSARCOMA phyllodes is a rare lesion related to fibroadenoma which is usually benign in its appearance and in its clinical course. A malignant variety is occasionally encountered. It is extremely important for the pathologist to differentiate between the benign and the malignant variety. This is usually not too difficult histologically. The malignant change usually involves the connective tissue element and only rarely the epithelial element.

Recently we encountered a breast lesion which fulfilled all the gross and microscopic criteria for a diagnosis of cystosarcoma phyllodes. We were also confronted with a second biopsy from the ipsilateral axillary lymph nodes showing on frozen section a metastatic epithelial neoplasm.

It is extremely rare for a patient to have both a cystosarcoma phyllodes and a coexistent adenocarcinoma of the same breast. In reviewing the literature, four cases of cystosarcoma phyllodes with coexistent adenocarcinoma in the same or opposite breast were found (Table 1). Lester and Stout[1] reported 58 cases of cystosarcoma phyllodes in 1954. One patient had both a cystosarcoma and an adenocarcinoma in the same breast. They also reported one case in which a cystosarcoma was excised and an adenocarcinoma developed in the same area four years later. Lee and Pack[2] described one case of cystosarcoma with an ulcerating adenocarcinoma of the opposite breast. Brown[3] in 1960 reported a case with cystosarcoma of one breast and adenocarcinoma of the other. In 1962 Hafner and associates[4] presented three cases of cystosarcoma including one case in which a small, obscure adenocarcinoma was found in the same breast after re-examination of the tissue because of the presence of lymph node metastasis.

Case Report. A 37-year-old unmarried white woman was admitted to St. Joseph's Hospital in November 1961. Her chief complaint was "a lump in the right breast." She first noted the lump in the upper outer quadrant of the right breast five days prior to admission. At that time, the lump was somewhat larger than a marble and was noticed while bathing. It was not painful, and there was no nipple discharge. The lump had enlarged rapidly since it was first noticed.

The patient had always noted engorgement of her breasts three days prior to her menstrual period. The heavy feeling always disappeared on the first day of menstruation. In the past several years, she had routinely examined her own breasts prior to menstruation. Three weeks prior to the time the lump was first noted, her self-examination was normal. The patient was an intelligent, well-educated nun who was a

pharmacist by training. Her past medical history and family history were noncontributory.

Physical examination revealed a well-developed, well-nourished woman who did not appear acutely or chronically ill. The only pertinent physical finding was the change in the right breast. A firm mass measuring approximately 10 cm. in diameter was noted in the upper outer quadrant. It was not fixed to the deep tissues nor to the skin, and there were no changes in the overlying skin. There was no nipple retraction or nipple discharge. The mass was nontender. There were several firm movable lymph nodes palpable in the right axilla, each of which measured approximately 1 cm. in diameter. The left breast and axilla were normal.

Frozen Section Consultation. The patient was examined by the pathologist before surgery. A 10 cm. firm, questionably cystic mass was palpable in the upper outer quadrant of the right breast. There was no skin or muscle attachment, and it was not tender. No nipple discharge or retraction was noted. The right axillary lymph nodes were enlarged and firm to palpation. The largest node measured about 2 cm. in diameter. The left breast had no masses and the left axillary lymph nodes were normal to palpation. The differential diagnoses included chronic cystic disease and adenocarcinoma. A biopsy with frozen section examination was recommended.

Findings at Surgery. With the patient under general anesthesia, a radial incision was made over the tumor in the upper outer quadrant of the right breast. A well-encapsulated tumor measuring about 5 to 7 cm. in diameter was dissected free.

Externally, it had a smooth pinkish-tan appearance and felt cystic. On cross section, the tumor burst forth in multiple papillary excrescences which were firm, rubbery, and edematous. They varied in appearance from a pale yellow to bright yellow. There were areas of edema and necrosis. The lesion appeared to be arising from a cyst-like cavity (Fig. 1).

The frozen section diagnosis was cystosarcoma phyllodes, probably benign type (Fig. 2). The lesion had no microscopic characteristics of malignancy, but because axillary adenopathy was present, a biopsy of the axillary lymph nodes was deemed imperative.

A lymph node measuring roughly 1.8 by 1.6 by 1.0 cm. was dissected free from the axillary tissue. It was very firm and on cross section was hard, gritty, and yellowish tan. The frozen section diagnosis was adenocarcinoma metastatic to the right axillary lymph nodes (Fig. 3). A right radical mastectomy and axillary lymph node dissection were performed.

Pathology Report. *Gross Description.* The entire right breast with pectoral muscles and right axillary fat pad was submitted for examination. The separate breast lesion and lymph node biopsy were as described at surgery.

The breast measured roughly 23 by 15.5 by 3 cm. An elliptically shaped portion of skin was present with a normal nipple and areola. An incision was noted near the

Fig. 1—Gross photograph of cystosarcoma phyllodes (larger lesion) and scirrhous adenocarcinoma (smaller lesion); centimeter rule.

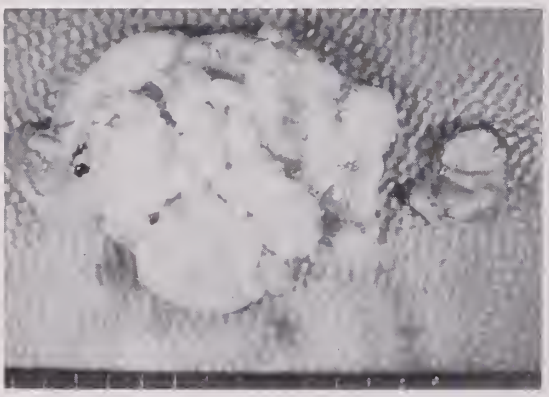
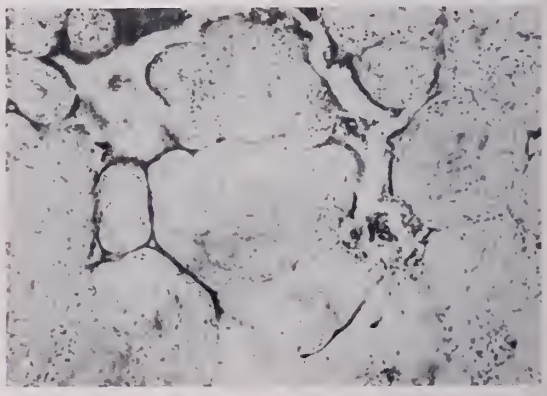


Fig. 2—Photomicrograph (hematoxylin and eosin, 35 X) of cystosarcoma phyllodes showing abutting polypoid masses with edematous connective tissue stroma and ductal epithelial covering.



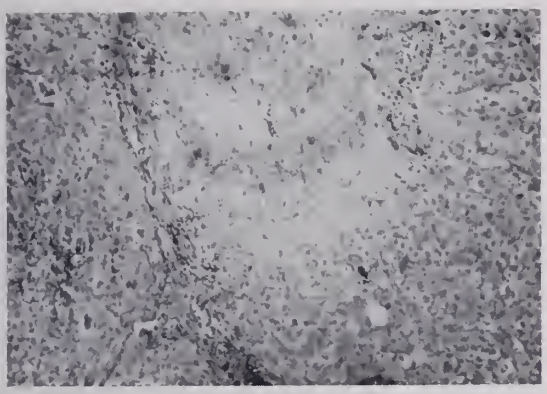


Fig. 3—Photomicrograph (hematoxylin and eosin, 100 X) of lymph node biopsy showing extensive replacement with adenocarcinoma.

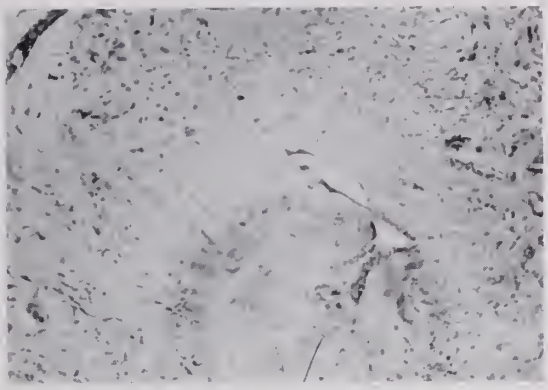


Fig. 4—Photomicrograph (hematoxylin and eosin, 100 X) of the scirrhous adenocarcinoma found by the surgical pathologist on dissection after mastectomy.

areola extending outward which measured roughly 6 cm. in length and had been closed with suture material. On multiple cross sections, no residual neoplasm was noted in the biopsy area.

A separate nodule was noted at a point 5.5 cm. medial to the biopsy site. The nodule was deep in the breast tissue and was very firm and gritty on cross section. It measured roughly 1.6 by 1 by 1 cm., was pale yellow to pink and well circumscribed (Fig. 1). Dissection of the axillary fat pad revealed 23 lymph nodes varying from 1 mm. to 1.4 cm. in diameter. Many of the nodes showed gross evidence of metastatic malignancy.

Microscopic Description. Multiple sections of tissue were present. The sections of tissue from the large tumor mass consisted of a large polypoid lesion with a pseudocapsule formation. The polypoid excrescences showed a stroma of fine connective tissue which was myxomatous in many areas. Many small capillaries were noted throughout the edematous stromal connective tissue. The excrescenses were covered by a thin layer of epithelium which was similar to ductal epithelium. In some areas, the cells were hyperchromatic but showed no malignant change. There were numerous clefts which were crescent-shaped and formed by abutting polypoid masses. Many of the polypoid masses showed extensive edema and early necrosis. In some of the sections, the lesion resembled a fibroadenoma. Sections of the small nodule from deep in the breast tissue revealed a typical scirrhous adenocarcinoma (Fig. 4). There was marked fibrous connective tissue proliferation in and about the tumor cells and areas of calcification were noted. The tumor cells were arranged in a cord-like fashion and some lymphatic and blood vessel infiltration was noted.

Final Microscopic Diagnoses. The final microscopic diagnoses were: (1) adenocarcinoma (scirrhous type) of the right breast; (2) cystosarcoma phyllodes (benign type) of the right breast; and (3) adenocarcinoma metastatic to the right axillary lymph nodes.

Subsequent Clinical Course. On Dec. 6, 1961, the patient had a bilateral salpingo-oöphorectomy and an incidental appendectomy. The right ovary contained a teratoma (dermoid cyst). The liver, spleen, kidneys, and other abdominal organs showed no abnormalities.

A course of irradiation therapy was begun on Dec. 19, 1961, and completed on Jan. 26, 1962. She received a total of 1,800 r to each of four fields: anteroposterior and posteroanterior (AP and PA), 20 by 15 cm. axillary and chest wall fields and AP and PA, 12 by 15 cm. supraclavicular fields. Factors were 250 KVP, 15 ma, 50 cm. distance, Thoraeus 0.4 mm. filter, hvl 2.4 mm. cu. She was treated every other day.

On Feb. 23, 1962, there was no evidence of axillary or supraclavicular lymphadenopathy and the mastectomy scar was well healed. The left breast and axilla were normal. A mild edema of the right upper arm subsided after a period of elevation.

On May 18, 1962, x-ray films revealed widespread bony metastasis to the rib cage, spine, and pelvis with a partial collapse of L-1. The patient died on Aug. 29, 1962, and no autopsy was obtained.

TABLE 1—*Coexistent Cystosarcoma Phyllodes and Adenocarcinoma*

Case No.	Age	Cystosarcoma	Adenocarcinoma	Axillary Metastases	Results
1. Lester and Stout	40	Benign	Same breast	?	No recurrence
2. Lee and Pack	52	Low-grade malignancy	Opposite breast	?	Died (adenocarcinoma)
3. Brown	49	Benign?	Opposite breast	Adenocarcinoma	No recurrence after one year
4. Hafner	32	Benign	Same breast	Adenocarcinoma	Died (adenocarcinoma)

Discussion. Cystosarcoma phyllodes is a rare lesion related to fibroadenoma of the breast. It is most often benign, but can be malignant. The malignancy usually involves the connective tissue only but very rarely may involve both the connective tissue and the epithelium. The problem in the reported case was the existence of an apparently benign cystosarcoma phyllodes and the presence of poorly differentiated adenocarcinoma metastatic to the ipsilateral axillary lymph nodes. The large, rapidly proliferating tumor mass which brought the patient to her physician was a benign neoplasm. Only on dissection of the amputated breast did the pathologist discover the malignant lesion deep in the breast tissue. The two lesions were unrelated and coincidental. The rapid growth of the larger lesion was most likely caused by interference with blood supply with resultant edema and necrosis. The importance of the presurgery frozen section consultation by the pathologist should be stressed. Because the pathologist was aware of the axillary adenopathy and actually palpated the abnormal nodes, he was in a better position to evaluate the situation and advise an axillary lymph node biopsy in this case. The usual treatment of a lesion of this type, with no evidence on frozen section of malignant change, would be excision alone with a diligent microscopic search of the entire lesion for possible malignant foci.

Summary: The case of a coexistent cystosarcoma phyllodes and scirrhous adenocarcinoma of the breast is presented, and the importance of differentiating the benign and malignant forms of cystosarcoma phyllodes is pointed out.

The possibility of more than one neoplasm being present in a single specimen should always be considered by the surgical pathologist, and the importance of the presurgical frozen-section consultation by the pathologist should be emphasized. A review of the literature reveals four other cases with the simultaneous presence of these two lesions.

207 South University; 209 South University.

REFERENCES

1. Lester, J. and Stout, A. P.: Cystosarcoma phyllodes, Cancer 2:335–353 (Mar) 1954.
2. Lee, B. J. and Pack, G. T.: Giant intracanalicular fibro-adenomyxoma: so-called cystosarcoma phyllodes mammae of Johannes Müller, Am. J. Cancer 4:2583–2609 (Oct) 1931.
3. Brown, M. J.: A rare combination of female breast tumors, J. Iowa S. M. S. 12:709–713 (Dec) 1960.
4. Hafner, C. D., Mezger, E. and Wylie, J. H., Jr.: Cystosarcoma phyllodes of the breast, Surg. Gynec. & Obstet. 1:29–34 (July) 1962.

U. of W. RESEARCH PROJECT USES STUDENTS AND FAMILIES

Students and their families who are admitted to the University of Wisconsin Infirmary with ailments caused by enteroviruses or intestinal viruses may not realize it but they are playing a part in an important research project being conducted by the State Laboratory of Hygiene and UW Medical Center.

Under supervision of Donald B. Nelson and Dr. Alfred S. Evans, director, of State Hygiene Lab, the study is aimed at isolating various types of enteroviruses. A correlation is being made between diagnostic and clinical findings of the patients in hopes of associating specific viruses with particular diseases.

Another procedure used is to study blood serum specimens of convalescing patients. The first sample is taken upon admission or when the virus has reached its most acute level. At that time, antibodies to this virus have had no chance to form within the body. A virus may be isolated then, but no guarantee can be made that it is the cause of the disease in question.

A second sample of blood serum is taken while the patient is recuperating. By this time, antibodies have had a chance to form, and their presence indicates that a particular virus was, in effect, the cause of the disease.

Of the entire enterovirus family, there are three groups which are found in approximately seven per cent of all isolation attempts. The first two, Coxsackie A and Coxsackie B, are similar to polio viruses, but are nonparalytic. The third group, called ECHO, are known as "orphan viruses," because they have no known associated disease syndrome.

The study, begun in December, 1961, is believed to be unique in taking advantage of a student population for the purpose of sampling.

Chlorpropamide in Treatment of Multiple Sclerosis

By G. F. TEGTMEYER, Jr., M. D., Madison, Wisconsin

■ STIMULATED by a recent report concerning the efficacy of an oral hypoglycemic agent, tolbutamide, in the treatment of multiple sclerosis,[1] a number of investigators have attempted to confirm the good results which were obtained. Thus far, for the most part, the findings have been disappointing.[2-4]

In an effort to extend the work with oral hypoglycemic agents, a study of chlorpropamide (Diabinase) in a modified double-blind method was instituted. The results have not been promising.

Materials and Methods. Patients were selected from the inpatient and outpatient Neurology Service of the University of Wisconsin Hospitals, Madison. Only those patients were accepted in whom the diagnosis of multiple sclerosis was firmly established, on the basis of clinical history and examination as well as pertinent laboratory findings. As a result many patients with their first signs and symptoms suggestive of multiple sclerosis were not included because of the uncertain diagnosis. Consequently, the patient population was composed of relatively long-standing cases, with histories of several exacerbations and remissions, or of steadily progressive, but widely disseminated central nervous system disease. Patients were apprised of the nature of the study, and were assured that if improvement should occur, the medication would be continued. The possibilities and the nature of hypoglycemic reactions were explained to all patients. Chlorpropamide or an identical appearing placebo was given to alternate patients as they presented. The physician administering the medicament was unaware of whether chlorpropamide or the placebo was being given, and the code was not broken until the study was completed. The dosage was started at one-half tablet (0.125 Gm. of chlorpropamide) daily and was increased to one tablet (0.250 Gm.) after seven days. No attempt was made to control the dietary carbohydrate or total caloric intake. After a trial of from two weeks to nine months, the patient was changed to the alternate compound if no improvement had occurred. No side reactions were noted except that one patient had symptoms suggesting a hypoglycemic episode. The "hypoglycemic" reaction, interestingly enough, was noted while the patient was on the placebo. It was not confirmed by blood-sugar studies. Some of the patients had glucose tolerance tests, and all had fasting blood sugars. Follow-up examinations were carried out in the outpatient department by various members of the neurology house staff. The patients ranged in age from 19 to 60 years, with an average age of 38. Duration of symptoms ranged from 7 weeks to 21 years. There were 12 women and 3 men in the group.

Results. Nine of the total of 15 patients were treated with chlorpropamide. Of these patients, one showed definite clinical improvement. This patient presented the typical picture of neuromyelitis optica, and over a period of several months showed gradual return of muscle strength to normal, but little change in her spasticity. Her vision also improved markedly. The medication was introduced seven weeks after the onset of symptoms, at a time when her neurological deficit was still progressing. After institution of the drug, her vision deteriorated further for two weeks, and then gradually improved. Three of the patients treated with chlorpropamide remained unchanged during the period of drug administration, four definitely were worse, and one was questionably worse.

Ten of the patients were treated at some time in their courses with the placebo. Two of these patients showed improvement, al-

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Supported by a grant from the Charles Pfizer & Co., Inc., and by National Institutes of Health Grant No. 2B–5098.

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though the degree was not impressive. Six of the patients were unchanged and one was worse.

Only five of the patients received both medicaments. Two of these showed no change on either medicament, two were unchanged while on placebo and worse while on the drug. One was worse on placebo and unchanged on the drug.

Summary. Within the limitations of this study, no evidence was found to suggest that chlorpropamide has any favorable influence on the course of multiple sclerosis. It is true that the patient population consisted chiefly of those whose disease was not of recent onset, and was relatively stable. Furthermore, no attempt was made to regulate carbohydrate intake, or to produce hypoglycemia. It is possible that a group composed of cases of recent onset or those with acute exacerbations might show some reversibility of symptoms and signs. In the patient group studied, however, the results were disappointing.

REFERENCES

1. Sawyer, G. T.: Treatment of multiple sclerosis with tolbutamide; preliminary report, J.A.M.A. 174:470–473 (Oct 1) 1960.
2. Elwell, R. H., Korsch, R. J. and Levens, A. J.: Multiple sclerosis; treatment with tolbutamide and diabetic diet, J.A.M.A. 179:724–726 (Mar 3) 1962.
3. Foster, J. B., Miller, H., Newell, D. J. and Kinlen, L. J.: Multiple sclerosis; trial of treatment with tolbutamide, Lancet 1:915–917 (Apr 29) 1961.
4. Poffenberger, A. L., Andersch, M. and Cotter, E. F.: Trial of tolbutamide in treatment of multiple sclerosis, Maryland Med. J. 10:582–587 (Oct) 1961.

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin.

1. **Interprofessional Code**
   An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

2. **Guide to The Service Corporation Law**
   A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

3. **Code of Necropsy Procedure**
   A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

4. **Hearing Conservation Programs for Wisconsin Industries**
   Some recommended standards and principles for providing a hearing conservation program in industry.

5. **Occupational Health, A Guide for Medical and Nursing Personnel**
   General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.

6. **Find Your Future in the Health Field**
   A career guide (the health careers brochure).

7. **Guide to Immunization Planning**
   An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

8. **A Guide for Physicians, Hospitals and News Media**
   A discussion of news relationships between physicians, hospitals, newspapers and radio and television stations. It includes information concerning patients, physicians and county medical society news, health educational efforts and advice on the use of the title "Doctor."

9. **Inspection of Medical Records**
   An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

10. **School Health Examinations**
    A guide for physicians and school authorities in establishing a program of school health examinations.

11. **School Vision Screening Program**
    An outline to facilitate the development of a program to detect significant visual defects among school children.

12. **First Aid Chart**

13. **Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959**
    Relating to fee splitting between physicians and others.

14. **The Doctor's Role in Adoptions**
    A reprint of three Wisconsin Medical Journal articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

Emphysema of the Face Following Bowel Resection

By VICTOR S. FALK, M. D., F. A. C. S., Edgerton, Wisconsin

■ RECENTLY Shambaugh and Burgert[1] presented a case of subcutaneous emphysema caused by a perforating carcinoma of the distal colon occurring spontaneously prior to surgical intervention. Their case was the thirty-ninth recorded instance of emphysema arising from the gastrointestinal tract and the fourth case associated with carcinoma of the colon. These same authors reviewed the literature and found 38 previously reported instances of subcutaneous emphysema arising from the gastrointestinal tract, with the origin ranging from peptic ulcer to anal fistula. Eight cases were recorded as arising from the colon. Three of these followed resection for carcinoma, three were after resection for diverticulitis, one was from perforation by barium enema, and the other was a spontaneous perforation of the carcinoma.

The case to be presented is unique in that the emphysema dissected upward through the mediastinum and involved the upper chest, neck, and face. It followed resection of the transverse colon for carcinoma.

Interstitial emphysema is the presence of a gas in soft tissue spaces. There are two types, subcutaneous and mediastinal. The subcutaneous emphysema may result in a grotesque appearance for the patient as he is literally blown up, but the situation usually is not serious. Mediastinal emphysema may be much more serious and usually is due to the escape of air from the trachea, bronchi or esophagus. Apparently mediastinal emphysema caused by gas from a leaking viscus is extremely rare. Pressure in the distended mediastinum may cause venous obstruction, dyspnea, cyanosis, and dysphagia.

Report of a case. The patient was a man 64 years of age, who had an infiltrating lesion of the distal transverse colon, diagnosed by x-ray films of the colon. Twelve years before he had had an orchiectomy for an embryonal carcinoma of the left testicle. This was followed by a brisk course of irradiation. Four malignant skin lesions had also been excised in the past. These were all of low-grade malignancy, and each was a different type pathologically.

There was no familial tendency toward malignancies as his father died at 85 of heart disease and his mother is still alive at 90 years of age.

Succinylsulfathiazole (Sulfasuxidine) and neomycin were administered preoperatively. The operation performed was resection of the transverse colon and primary end-to-end anastomosis. The specimen consisted of 30 cm. of transverse colon with attached greater omentum measuring 45 by 20 cm. The lesion measured 9.5 cm. in transverse diameter and almost completely encircled the lumen. It was 7 cm. in length. The pathological diagnosis was carcinoma of the transverse colon with no metastatic involvement of the regional lymph nodes.

The immediate postoperative course was smooth. Active peristaltic sounds were noted on the first and second postoperative days, and the nasogastric suction was discontinued on the third day. Good results were obtained with enemata. The patient complained of abdominal distress on the eighth day and moderate distention was noted despite the passage of flatus. On the ninth day, the patient's temperature rose to 103 F., and a small fluctuant area was present at the upper end of the incision. Some fullness of the face was discernible bilaterally and "surgical mumps" was considered.

On the tenth day, the patient's voice was weak, strained, and higher pitched than normal. The neck was tremendously distended, the face was puffy and both eyes were swollen shut. The extreme subcutaneous emphysema of face made the patient unrecognizable. Crepitation was palpable beneath the skin of the face, neck, and upper

Fig. 1—Posteraanterior view of chest. Mediastinal emphysema has dissected along the superior mediastinum bilaterally. There is alsa same subcutaneaus emphysema extending over the anteriar chest wall, especially on the left.

chest. The upper end of the abdominal incision was also bulging and crepitant. A small incision was made and a large amount of gas and liquid feces escaped.

X-ray films were made of the abdomen, chest, neck, and head. Views of the abdomen revealed free air as well as subcutaneous emphysema of the abdominal wall. The lung fields were partially obscured by the subcutaneous emphysema. Air could be visualized dissecting upward within the mediastinum, especially in the superior mediastinum and surrounding the aortic knob. Films of the skull and neck showed air in the retropharyngeal space originating from the mediastinum, as well as marked subcutaneous emphysema.

Later the same day a large amount of liquid stool poured out of the incision when the patient stood. The subcutaneous emphysema of the neck began to subside the same day, although the puffiness in the infraorbital areas was still massive.

Fig. 2—Lateral view af cervical spine. Air is present in the retrapharyngeal space with subcutaneaus emphysema over the entire neck. The retropharyngeal air is an extensian fram the mediastinal emphysema.

The abdomen became less distended and the emphysema of the chest, face, and neck decreased progressively. Fortunately, no mediastinitis or cellulitis developed, and no incision was necessary other than the small one made at the upper end of the original left paramedian incision.

His temperature promptly returned to normal. The diet was again increased. Some semisolid stool passed through the fistulous tract, but this gradually decreased. The patient was discharged three weeks after surgery. A barium enema was repeated a week later and showed extravasation in five different directions in which fistulous tracts extended from the anastomosis. Four months later a sinusgram demonstrated a long, subcutaneous sinus tract but no definite communication with the bowel.

For nine months postoperatively the patient was distressed by the intermittent escape of gas through the small opening in the abdominal wall. This finally closed spontaneously a year ago.

Summary. Interstitial emphysema may be subcutaneous or mediastinal. Previously 39 cases of subcutaneous emphysema arising from the gastrointestinal tract were recorded. There were four which originated with carcinoma of the colon.

A case of combined mediastinal and subcutaneous emphysema of the face and neck has been presented. This followed resection of the transverse colon for carcinoma, and thus is the fifth reported case originating in a colon carcinoma.

This case was unusual because of the involvement of the mediastinum, retropharyngeal space, neck and face, as well as the abdominal wall. Fortunately, no mediastinitis or cellulitis developed. Prompt relief was obtained following a small incision of the recent abdominal scar.

Mediastinal emphysema usually follows escape of air from the esophagus, trachea, or bronchi. It is an unusual complication of a leaking abdominal viscus.

5 West Rollin Street.

REFERENCE

1. Shambaugh, P. and Burgert, P. H.: Subcutaneous emphysema in cancer of colon, A.M.A. Arch. Surg. 85:344-347 (Aug) 1962.

Leiomyoma of the Fallopian Tubes

By AARON H. LIPTON, M. D.

Milwoukee, Wisconsin

■ AS STATED by several authors,[1-3] leiomyoma of the fallopian tube is a relatively rare lesion, not commonly reported, although certain numbers of unreported cases may exist. The first reported case was by Baille in 1818[1] and since that time scattered reports have been found in the European and American literature. To date, 51 cases have been found and reported in the literature, the last 2 by Chalmers.[2] This is the fifty-second to be found and reported.

Among gynecologists and pathologists, there is a general belief that the incidence of leiomyoma of the fallopian tube, embryologically equated, should be greater, recognizing the common origin of both uterus and fallopian tubes from the müllerian ducts.[4] In a report by Kelly and Cullum in 1909[5] of a series of 934 leiomyomata, only one tubal myoma was found. The paucity of these tubal lesions may be explainable by the greater effects of cyclic changes on the uterus during the menstrual cycle as well as pregnancy, which do not occur in the fallopian tube to any great extent.

The tumor is more commonly single, although occasional multiple lesions are seen. Most cases report the lesions on the left side, and it is usually seen in the mid-portion or more towards the uterine portion of the fallopian tube. It may be subperitoneal, interstitial or submucous in position. The lesions are usually small, although a leiomyoma weighing nearly 2 kg. has been reported.[3] They have the same histologic appearance as do uterine fibroids with which they are frequently associated. In the second of the only two cases that were reported from the Scandinavian countries, Holund[6] describes one in which he believes the etiology is caused by congenital atresia of the uterine half of the salpinx. It is interesting that no presurgical diagnosis of fallopian tube leiomyoma has ever been proposed. The major reported neoplasms of the fallopian tube are either primary carcinoma, chorio-epithelioma, or adenomyoma.

The following case is reported from a Veterans Administration hospital of approximately 1,200 beds with a census of approximately 25 female patients.

Case Report. A 46-year-old para III, gravida III, white woman was admitted to the hospital on April 10, 1961, because of a

Fig. 1—Gross photograph of lesion revealing fimbria at left and small portion of cornu at right.

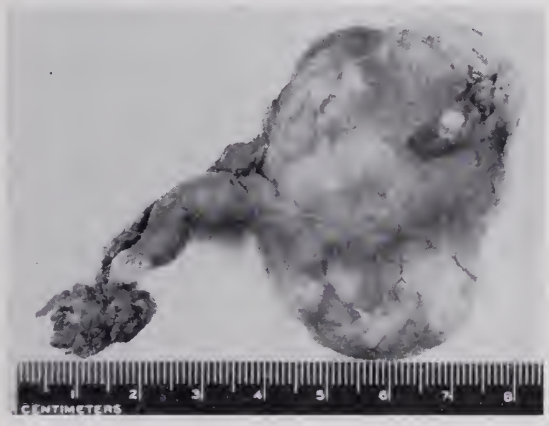

Fig. 2—Cut section of lesion revealing the usual raised whorling pattern of interlacing bundles of smooth muscle.

From the Departments of Pathology, VA Center, Wood, Wis., and Marquette University, School of Medicine.

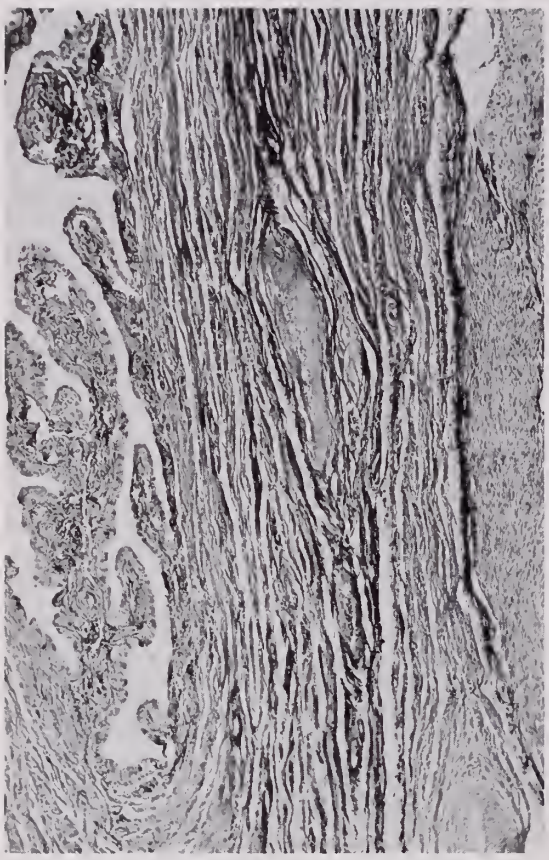

Fig. 3—Low-power photomicrograph revealing fallopian tube lumen left and wall of leiomyoma right.

Fig. 4—Photomicrograph of leiomyoma showing classic pattern of interlocing smooth muscle fibers.

right adnexal mass first noted on pelvic examination 10 months before. At the time of the discovery of the mass, the patient's chief complaint was dull, intermittent, nonradiating, right lower quadrant pain causing minimal distress. Subsequently, the discomfort became more continuous and of greater intensity, lasting throughout most of her 28-day menstrual cycle, but becoming more severe the week prior to the onset of menses. In addition, the patient complained of yellowish, nonodorous, nonirritating vaginal discharge present throughout her menstrual cycle. This discharge was not sufficiently copious to require wearing of a pad. She had been treated by cautery to the cervix in the summer of 1960, with no improvement. Past history and review of systems revealed no significant illness except for brucellosis 20 years before. Vital signs and physical examination showed normal findings except for the pelvis. Pelvic examination revealed a 3 by 5 cm., firm, smooth, mobile mass in the right adnexa and a suggestion of fibroids of the uterus. Laboratory examinations including a Papanicolaou smear of the cervix, urinalysis, white blood cell count, red blood cell count, bleeding and clotting times, sulfobromophthalein sodium retention, hemoglobin level, and hematocrit reading were all within normal limits. Prothrombin time and syphilis test (VDRL) were also normal. Proctoscopy to 20 cm. was performed, and only external hemorrhoidal tags were noted. At surgery a 6-cm. lesion of the right fallopian tube was removed by salpingectomy, and a hysterectomy was performed. Examination of the myometrium revealed encapsulated nodules of varying size. None of these nodules was found in a submucous or serosal position, as all were completely intramural. The patient withstood the procedure well, and postoperatively the course was unremarkable.

Gross examination of the right tubal lesion revealed an encapsulated mass of tissue weighing 55 Gm. and measuring 6 by 4 by 3

cm. The attached fallopian tube appeared to course along the surface of this tumor for a distance of 4 cm. The tumor was firm and on multiple sections was composed of a firm, rubbery, gray-yellow, glistening tissue with the suggestion of a whorled appearance. The tissue bulged moderately on section. Streaks of gray-white tissue coursed through the tumor producing a lobular pattern.

Microscopic examination of multiple sections showed the lesion arising from the subperitoneal aspect of the fallopian tube. The tumor was composed of variable-sized interlacing bands of well-differentiated, smooth muscle fibers producing a whorled pattern. Nuclei were elongated with rounded ends and contained finely granular regularly dispersed chromatin. In focal areas the whorled, smooth muscle was separated by narrow bands of fibrous tissue. Vascular channels were present within the tumor. The tumor was surrounded by a pseudocapsule of compressed fibrous connective tissue. In addition, the patient had myometrial leiomyomata, which showed the same histologic pattern as the fallopian tube tumor. The endometrium revealed relatively abundant secretory type of epithelium, and the ovaries were unremarkable except for corpora albicantia. Also, the patient had a chronic cervicitis.

Summary. This fifty-second reported case of leiomyoma of the fallopian tube is presented in an effort to alert the clinician to include this entity in the differential diagnosis of pelvic pain, discomfort, and mass in the pelvic adnexal area, or both. At surgery, the finding of a fallopian tube tumor should include the following differential diagnoses: (1) granuloma, (2) metastatic tumor, (3) primary malignancy, (4) ectopic pregnancy, (5) leiomyoma of the fallopian tube, and (6) adenomata of the fallopian tube.

To date there are no reports of leiomyoma of the fallopian tube diagnosed prior to surgery.[7] There appears to be no particular pattern, symptoms, or signs except for the relatively common complaint of pelvic discomfort of a progressive nature more prominent just prior to or with the onset of menses.[8]

West National Avenue at 54th Street.

REFERENCES

1. Bailee, M.: *Morbid Anatomy of Some of the Most Important Parts of the Human Body*, 5th ed., London, 1818.
2. Chalmers, J. A.: Fibromyoma of the fallopian tubes; report of two cases, Scot. Med. J. 3:185–186 (Apr) 1958.
3. Graves, W. P.: *Gynecology*, 4th ed., Philadelphia, W. B. Saunders, 1928, p. 532.
4. Chalmers, J. A.: Hydatidiform mole in fallopian tube, J. Obstet. & Gynec., Brit. Emp. 55:322–324 (June) 1948.
5. Kelly, H A. and Cullen, T. S.: *Myoma of the Uterus*, Philadelphia, W. B. Saunders Co., 1909, p. 341.
6. Holund, Tage: Fibromyoma of the fallopian tube, Acta Obstet. & Gynec. Scand. 27:390, 1947–1948.
7. Seidner, H. M. and Thompson, J. R.: Fibroma of the fallopian tube, Am. J. Obstet. & Gynec. 79:32–33 (Jan) 1960.
8. Meyer, Julius: Case of fibromyoma in fallopian tube, Finska läk.-sällsk., handl. 69:43–48 (Jan) 1927.

APPLICATIONS OPEN FOR PEDIATRIC RESIDENCY FELLOWSHIPS

Wyeth Laboratories has announced that applications are now being accepted for its seventh program of Pediatric Residency Fellowships.

Eligible to apply for the fellowships are interns and young physiciáns who, while having a strong desire to specialize in pediatrics, would find it difficult or impossible to finance the two-year postgraduate training required for Board certification.

Each Wyeth Pediatric Fellowship provides $4800 for the two-year period. Monthly allowances are made directly to recipients, in addition to the stipends normally paid residents by the institutions where they are in training. Fellows are free to choose their place of residency from among institutions accredited by the AMA's Residency Review Committee of the Council on Medical Education and Hospitals, the American Board of Pediatrics, and the American Academy of Pediatrics.

Applicants must be citizens of the United States or Canada, and awards are limited to interns, young physicians who have recently completely internships, physicians coming out of the armed services or U. S. Public Health Service, or to research Fellows.

Wyeth takes no part in the selection of the Fellows. Instead, award recipients are chosen by a special volunteer Selection Committee of pediatricians who, collectively, represent outstanding accomplishments in the fields of pediatric practice, research and teaching.

Inquiries concerning the program should be directed to Dr. Philip S. Barba, University of Pennsylvania School of Medicine, Philadelphia 4, Pa.

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CHILDHOOD LEUKEMIA—A PAMPHLET FOR PARENTS. Prepared for distribution by physicians to parents of leukemic children. Released by the National Cancer Institute, Public Health Service, Department of Health, Education, and Welfare. Available to physicians only, free of charge, from the Office of Information and Publications, National Cancer Institute, Bethesda 14, Md.

CLINICOPATHOLOGIC CONFERENCE

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Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: PEARSE MEIGHAN, M. D.
Appleton, Wisconsin

Case Presentation.* A 22-year-old white primigravida was admitted to the hospital on February 28 at 6:10 a.m. in labor. Her estimated date of confinement was February 16. The patient's prenatal course had been uneventful. She was 5 feet 2 inches in height and had a normal weight of 120 pounds. During this pregnancy she gained 20 pounds. There had been no elevation of blood pressure and no albuminuria. Serology was negative. Her hemoglobin level was 13.4 Gm. per 100 ml. and hematocrit reading was 47%. Her blood type was A-Rh positive.

Her past medical history was negative except for a reported back injury in high school which caused some kind of disability in the form of recurrent backache. At the time of her injury she had x-ray studies and a course of injection treatments. Her only sibling, an older sister, had died in childbirth, approximately five years previously.

Examination at 8:30 a.m. showed the patient to be in active labor. The infant was in the left occiput posterior position, with the vertex at station 0. Fetal heart tones were heard in the left lower quadrant at a rate of 140 and were regular. The cervix was dilated to 3 to 4 cm. and the membranes were bulging. Contractions were of variable intensity at 5-minute intervals. The patient appeared calm and relaxed. Amniotomy was performed and a moderate amount of normal appearing amniotic fluid was passed vaginally. Fetal heart tones immediately following the amniotomy were unchanged. At 9:45 a.m., 50 mg. of meperidine hydrochloride (Demerol) and 50 mg. of promethazine hydrochloride (Phenergan) were given intramuscularly. This was repeated at 12:45 p.m., together with atropine sulfate grains 1:150. The patient appeared to relax completely throughout the labor and voiced no complaints. The cervix was completely dilated at 1:20 p.m. She was taken to the delivery room at about 2:45 p.m. At that time the infant's head had descended well into the pelvis, although there was considerable moulding and some caput formation. She was encouraged to push with her contractions for a 15-minute period in the delivery room. Under general anesthesia, and with a midline episiotomy, a modified Scanzoni's midforceps rotation from left occiput posterior to left occiput anterior, with two applications of Tucker–McLean forceps was accomplished. Extraction from the anterior position was then done without undue traction. A living male infant was delivered, and he breathed and cried spontaneously and immediately. No resuscitation was required for the infant. The placenta, which separated with the next contraction, was found to lie partly within the cervix and upper vagina. It was removed manually, and there was no undue bleeding at this time.

Examination of the cervix revealed no lacerations. There was a vaginal laceration on the left side, which together with the episiotomy was repaired. An obstetrical consultant assisted in this procedure. A Foley catheter was inserted into the bladder. Blood loss during the entire procedure was estimated at less than 400 ml. Toward the close of the procedure the anesthetist noted that the patient was hyperventilating and the anesthetic was discontinued. A solution of 1,000 ml. of 5% glucose and water was given intravenously. At this time it was noted that the patient's blood pressure was now about 95/40 and the pulse rate was about 160, and that she was hyperventilating and perspiring profusely. She was also fully awake and responded well. After observing the patient for one-half hour she was removed to the recovery room.

A medical consultant saw the patient one and one-half hours after delivery. The rectal temperature was 104 F. She had a sinus tachycardia of 150 per minute and seemed to be in semishock and not aware of her environment, threshing her head about. The pupils were equal. There was no rigidity of the neck. The mouth and pharynx were not remarkable. The heart rhythm was regular. There was no cardiac enlargement. There

* From Appleton Memorial Hospital.

were no wheezings nor evidence of rales or friction rub. The remainder of the physical examination was not remarkable. The patient was supported with fluid, *l*-norepinephrine (Levophed), antibiotics, hydrocortisone sodium succinate (Solu-Cortef), oxygen, shock position, and intravenous antibiotics. She continued to perspire profusely and became disoriented. There was practically no external bleeding, but terminally her temperature rose to 106 F. rectally, and she died at approximately 7:15 p.m. on February 28.

Discussion. *Dr. E. H. Raney:* The suddenness of the episode is striking, as is the point brought out that her sister died in childbirth five years prior. The negative past medical and obstetrical history would tend to rule out toxemias of pregnancy, central nervous system lesions, adrenal insufficiency, and cardiac disease, congenital or otherwise. It would also tend to rule out the more recently reported myocarditis with pregnancy[1] for these cases have had preadmission symptoms of heart failure.

The suddenness of the accident shortly after the exertion of labor, as well as having her sister die in childbirth, would make one think almost immediately of rupture of a cerebral saccular aneurysm. The abrupt spike in temperature to 104 F. and then to 106 F. would support this diagnosis. The lucidity of the patient does not distract from this diagnosis, for many patients may remain lucid during the clinical course of a ruptured aneurysm. On the other hand, ruptured aneurysms may occur during pregnancy but do not have an increased incidence during pregnancy. The lack of headache, nuchal rigidity, localizing signs, and decrease in blood pressure are strong deterrents to this diagnosis.

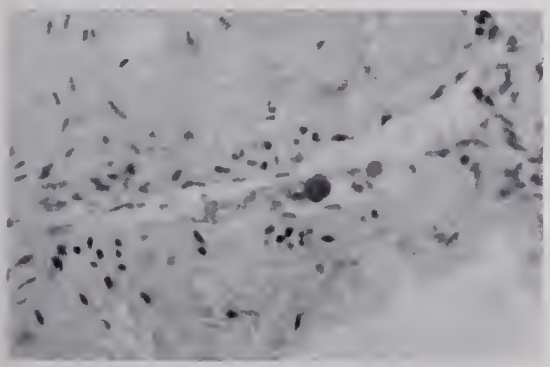


Fig. 1—Photomicrograph of small pulmonary artery containing mucus from amniotic fluid.

The most striking signs in this case are the reduction in the blood pressure, increase in pulse rate, and the cold clamminess as seen in shock. Shock in such a clinical situation can be considered as hypovolemic or normovolemic in type. In the hypovolemic state there is usually a loss of the intravascular fluid, while in the normovolemic type the intravascular fluid volume is essentially normal. In those types resulting in hypovolemia, one must consider blood loss which could be due to obstetrical trauma, ruptured uterus, or rupture of congenital splenic aneurysm. The latter would be a hidden intraperitoneal type of hemorrhage. Even though the amount of blood loss at the delivery table is usually underestimated, and the protocol here shows that she lost 400 ml., there is no other firm evidence to support blood loss as the primary cause of shock in this patient.

In adrenal insufficiency, a hypovolemic type of shock can occur and is due to the loss of blood volume secondary to the marked loss of electrolytes. This is a similar finding in cardiac decompensation and in toxemias where diuretics have been used and a large amount of electrolytes have been lost. In pulmonary edema, the loss of intravascular fluid is usually into the pulmonary bed. A similar picture, only in another phase, would be acute peritonitis. In acute peritonitis, the edematous fluid collects in the peritoneal cavity rather than in the lungs, as is the case in pulmonary edema. All of these are relatively severe and are of hypovolemic type.

In the case under discussion there is no past history to indicate any evidence of severe cardiac decompensation giving a secondary pulmonary edema, nor is there any evidence of adrenal insufficiency, nor was the patient given any diuretics. The patient also on admission had no recorded temperature elevation or any other symptoms which would suggest peritonitis or infection of any sort.

Normovolemic types of shock are seen when there is decreased cardiac output as in cardiac tamponade, or in pericardial effusion, mediastinal emphysema or tension pneumothorax. These, however, can be easily ruled out here by lack of any physical finding. In this group, however, the most important are the pulmonary embolizations which can occur frequently and readily in obstetrics. These can cause a profound normovolemic type of shock and often are lethal. The size of the

embolus does not seem to determine the severity of the shock, and it is probably due to neurological causes rather than any of the other known causes of shock.

All forms of embolization should be considered here. Vascular embolization occurs frequently, however it is usually later in the puerperium and most often about the seventh day. It is usually preceded by a history of venous thrombosis and at its onset causes chest pain, pseudopericardial friction rub, and evidence of pulmonary hypertension, none of which were present in this protocol. Air embolus can cause a similar picture. It is rare at the delivery table and may be excluded by the absence of a churning or water-wheel type of murmur in the heart. Fat embolus should be considered, especially because this patient had a lateral gutter laceration. It could occur in any patient with a laceration in which free fat is exposed. It is important because it is a treatable disease, and fat can often be found on examination of the sputum or urine.

In this case, however, amniotic fluid embolism has the most support by the history of early rupture of the membranes, trauma at final delivery, and the sudden acute shock picture with negative physical findings, even though rales can often be heard in the lung fields after an amniotic fluid embolus. It is my contention that the primary cause of shock and of death in this patient was an amniotic fluid embolus.

Dr. George Petersen: As attending physician I was present during most of the labor, the delivery, and the post-partum period. As noted in the presentation and previous discussion the labor and delivery proceeded as might be expected in the case of a young primigravida with a posterior position. There was no warning of a serious problem until the immediate post-partum state. The possibility of amniotic fluid embolism was considered and appropriate consultation was sought early. All attempts at reversing the course of events were to no avail and the patient's condition steadily deteriorated.

Most reports of cases of amniotic fluid embolism have noted the following: The patient is often a multipara in her thirties with a tumultuous labor. The antepartum use of oxytocin (Pitocin) has been frequently noted. None of these conditions pertain in this case.

Here we had a young, generally healthy, primigravida with a normal prenatal course and not an unusually difficult labor or delivery. The most disturbing fact in her history was that a sister had died previously in childbirth. A deep anesthetic was required in order to effect rotation and delivery of the infant, but was continued only for a short time. Because of the history of back injury and some misgivings on the part of the patient, inhalation anesthesia was used instead of the more preferred conduction anesthesia. At no time did I feel that the purely obstetrical situation was out of control. There was no hemorrhage or serious maternal injury nor was there any indication of injury to the infant who subsequently did well.

It was known that the woman's family with their previous tragic experience had been firmly opposed to her marriage and subsequent pregnancy. It is believed, somewhat in retrospect, that despite the patient's calm demeanor, she must have been very fearful of labor and delivery. The psychological stresses acting upon this woman were probably not fully appreciated by her attendants. I believe that the stresses to which this young woman was subjected were the prime factor in causing her death. A presumptive diagnosis of amniotic fluid embolus may be based on clinical grounds when the patient recovers, but the diagnosis is usually based on microscopic findings in the lungs at postmortem. We know that it is not unusual to find evidence of lesser degrees of embolization in otherwise normal pregnancies. I have seen fatal amniotic fluid embolism before and the changes in the lungs were much more striking than in this case.

Dr. George P. Nichols: Some doubt has been expressed in the discussion about the diagnosis of amniotic fluid embolism in this case, and about the possibility that such an entity exists. I must confess that this was my initial reaction also before a more thorough study of the literature and before my experience with another case seen recently in another hospital. If one depends solely upon one's own clinical experience, then the unusual entities in medicine are difficult to recognize. This entity of amniotic fluid embolism is uncommon in any one physician's experience, at least fatal instances, such as the case presented here.

Experimentally, the evidence for the existence of this condition is well founded. The

intravenous injection of unfiltered amniotic fluid has consistently reproduced this syndrome and these pathologic findings in experimental animals. The injection of filtered amniotic fluid is not followed by this syndrome. Apparently a variable amount of amniotic fluid debris is responsible, and the amount may be small.[2] Publication of cases (now numbering about 100 fatal cases), reviews, and editorial articles are found largely in the obstetrical journals.

This condition now has outgrown its newness and should be more promptly recognized. It is important for the internist as well as the obstetrician to be familiar with this condition, since frequently an internist has been called to see these patients who rather uniformly present the picture of painless shock developing in the delivery room (or shortly thereafter) where trauma, blood loss, toxemia, and other causes of shock do not seem to be present or responsible. The woman is apprehensive, dyspneic, and in peripheral vascular shock without apparent reason.

The findings of pulmonary edema are often in evidence on physical examination, or by chest x-ray film, and even the electrocardiogram may show unexpected abnormalities. If the patient survives the first few hours, hemorrhagic phenomena may appear. A large list of differential diagnoses may be considered, but amniotic fluid embolism is by far the most likely cause of shock in a patient presenting these findings. At least a small number of cases of amniotic fluid embolism with survival have been reported, and it is suspected that more than a few nonfatal cases escape recognition, being manifest only by a lesser degree of idiopathic shock in the delivery room. Without pathologic and necropsy evidence, these cases are difficult to confirm, but the inference is clear.

The practical importance of recognition may soon be increased because of recently published experimental data which show that this syndrome is consistently prevented and cured by the administration of isoproterenol (Isuprel), either by inhalation or injection.[3] This type of treatment has not been reported yet in human cases but should be well worth remembering. Treatment otherwise is purely supportive. Vasopressors and the avoidance of circulatory overloading with excessive intravenous fluids are believed to be important therapeutic factors. Amniotic fluid embolism then should always be considered as probably the most likely cause of idiopathic shock in the delivery room.

Autopsy Findings. *Doctor Meighan:* Gross autopsy examination was marked by a paucity of notable alterations. The only notable gross changes were seen in the lungs where there were patchy atelectasis and focal hemorrhages. Microscopically, also, the chief alterations appeared to be in the lungs. There were focal areas of emphysema and patchy atelectasis with focal hemorrhage. More important, however, were small arteries and capillaries containing a dark brown amorphous debris and, in some instances, a uniform amphophilic substance. Occasionally this latter material was associated with large clumps of platelets. This material was distinct from fibrin and definitely foreign to the normal vascular content. It is interpreted as evidence of amniotic fluid and, more specifically, as representing the mucus of meconium. Squamae and lanugo hairs and mucus constitute the microscopic evidence of amniotic fluid embolization.[4] Lanugo hairs and squamae were not identified in this case.

As noted in the previous discussion, there are often two clinical components in the condition of amniotic fluid embolization. First is the profound shock and second is the hemorrhage which often follows in cases of patients who survive this initial period. Massive pulmonary embolization can result in mechanical obstruction of the pulmonary vessels, however in some cases there appears to be insufficient obstruction of the pulmonary circulation to explain death. In these cases it is suspected that some type of sensitivity reaction with reflex vasospasm of the nonoccluded vessels occurs as a reaction to the foreign material. With respect to the pathogenesis of the second or hemorrhagic phase, it appears that defibrination is the usual clotting defect which may complicate these cases. It should be noted however, that there may also be a heparin-like total inhibition of coagulation with continued normal fibrinogen levels.[5]

REFERENCES

1. Becker, F. F. and Taube, H.: Myocarditis of obscure etiology associated with pregnancy, New Engl. J. Med. 266:62–67 (Jan 11) 1962.
2. Halmagyi, D. F., Starzecki, B. and Shearman, R. P.: Experimental amniotic fluid embolism; mechanism and treatment, Amer. J. Obstet. Gynec. 84:251–256 (July 15) 1962.
3. Ibid

continued on page 441

COMMENTS ON TREATMENT

Presented through the cooperation of the pharmacology departments of the University of Wisconsin Medical School, Madison, and the Marquette University School of Medicine, Milwaukee

HAROLD F. HARDMAN, M.D., Ph.D., Editor
Marquette University School of Medicine

Antithyroid Drugs

By DEANE N. CALVERT, Ph. D.
Milwaukee, Wisconsin

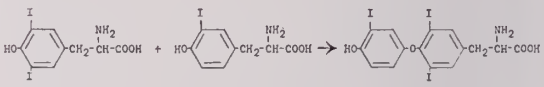
■ AN OBSERVATION in 1928[1] that rabbits fed upon a diet of cabbage developed hyperplastic goiters led to the development of a group of drugs useful for the treatment of hyperthyroid conditions. Animal experimentation with these drugs, moreover, has led to a much clearer understanding of the events that occur within the thyroid gland under normal conditions.

The biochemical events occurring in the thyroid may be briefly summarized as follows:

1. *Trapping of inorganic iodide (I^-) by the gland.* This phase of hormone synthesis is energy requiring and is promoted by the thyroid stimulating hormone (TSH) of the anterior pituitary, although complete control of the process does not rest with the anterior pituitary since trapping still occurs in the hypophysectomized animal. The inorganic antithyroid compounds perchlorate and thiocyanate inhibit the trapping of iodide by the gland presumably through a competitive inhibition of the enzyme or enzymes responsible for the process. A congenital lack of this trapping mechanism has been reported in some goitrous children with hypothyroidism.[2]

2. *Conversion of trapped iodide to iodinated tyrosines.* This process involves oxidation of the iodide to either free iodine or hypoiodite, which in turn acts upon the tyrosine molecules within the thyroidal proteins to form monoiodotyrosine and/or diiodotyrosine. No evidence exists for a direct role of TSH upon this phase of thyroid hormone production. The thiouracil derivatives (for example, propylthiouracil) have been shown to inhibit this phase of thyroid hormone synthesis probably by the inhibition of the enzymes responsible for the oxidizing of iodide to the active form. As with the trapping mechanism, a congenital lack of the enzymes responsible for the oxidation process has been described.[3] The lack of such enzymes leads to cretinism and goiter.

3. *Condensation of iodotyrosine to iodothyronines.* This is the final step in the synthesis of the hormones. No good evidence



(or 2 molecules of diiodotyrosine condense to form 3,5,3',5' tetraiodothyronine [thyroxine])

exists for a direct action of either TSH or of the antithyroid compounds upon this step in the synthesis of the hormones. A congenital defect in the ability of the thyroid gland to couple iodotyrosines has been reported,[4] but it is unknown if a coupling enzyme is missing or if it is an abnormal conformation of the thyroglobulin molecule which is the congenital defect.

4. *Secretion of thyroid hormones into circulation.* The hormones are stored within the gland in the thyroglobulin or colloid. Proteolytic enzymes release the iodinated compounds from the colloid. These include thyroxine, triiodothyronine and the iodinated tyrosines. The latter are inactive as hormones. The proteolytic enzymes are under the control of TSH. No antithyroid drugs are known which act directly on the secreting mechanisms. Large quantities of iodide prevent the release of the hormones, perhaps

through an inhibitory action on the TSH effect. The mono- and diiodotyrosines released by the proteolytic enzymes ordinarily are deiodinated and the iodide is reused in hormone formation. Goitrous cretinous children, however, have been found in which the dehalogenating enzyme is lacking and the iodotyrosines (and hence a complement of the glandular iodide) are lost in the urine.

Antithyroid Drugs

CLASS OF COMPOUND	EXAMPLE
1. Inorganic	Perchlorate Thiocyanate
2. Organic	
(a) Thiocarbamyl and thiocarbamyl compounds	Propylthiouracil Methimazole
(b) Aminobenzene and aminoheterocyclics	p–Aminosalicylic acid (PAS)* Carbutamide*

* Of importance since they are likely to be chronically used as antitubercular (PAS) or oral hypoglycemic (carbutamide) compounds and may thus interfere with thyroid function in patients on such therapy. More importantly though, they interfere with thyroid function tests.

The toxic effects of these drugs are not exceptional and usually do not prevent their use. Most side effects commonly mentioned include hypersensitivity allergic reactions as manifested by (a) skin reactions (3 to 5 per cent of patients), (b) granulocytopenia and agranulocytosis (5 per cent of patients), and (c) a group of miscellaneous toxic manifestations such as drug fever and occasional hepatic damage.

A highly individualized regimen of treatment must be developed for each patient receiving antithyroid therapy. However, Selenkow and Collaço[5] suggest a general treatment consisting of administration of thyroid hormone along with the antithyroid drug after the antithyroid drug has achieved a euthyroid state in the patient. They suggest that the advantages of such a program are: (1) it prevents the occurrence of hypothyroidism, (2) it appears to reduce goiter development, (3) it seems to modify the degree of exophthalmus and to be effective in controlling milder ophthalmopathy, and (4) it puts the thyroid completely at rest without producing hypothyroidism.

REFERENCES

1. Chesney, A. M., Clawson, T. A. and Webster, B.: Endemic goiter in rabbits, Bull. Johns Hopkins Hospital 43:261, 1928.
2. Blizzard, R.: Inherited defects of thyroid hormone synthesis and metabolism, Metabolism 9:232, 1960.
3. Stanbury, J. B. and Hedge, A. N.: A study of a family of goitrous cretins, J. Clin. Endocrinol. 10:1471, 1950.
4. Stanbury, J. B., Ohela, K. and Pitt-Rivers, R.: The metabolism of iodine in two goitrous cretins compared with that in two patients receiving methimazole, J. Clin. Endocrinol. 15:54, 1955.
5. Selenkow, H. A. and Collaço, F. M.: Clinical pharmacology of antithyroid compounds, Clin. Pharmacol. Therap. 2:191, 1961.

SURGEON GENERAL RECOMMENDATION ON SMALLPOX VACCINATION

Surgeon General Luther L. Terry has recommended that persons who work in and around international seaports, airports, and land border points of entry, and those who meet and treat the sick, be vaccinated against smallpox at least every three years and preferably every year.

The recommendation in no way affects the present vaccination requirement for persons entering the United States. They must have been vaccinated within the past three years.

Commenting on the recommendation, Dr. Terry said: "Its purpose is to increase and maintain at a high level the protection against smallpox of those persons who are most likely to have contact with an infected international traveler. These persons include port workers; airline and shipping company employees; taxi, bus, and ambulance drivers; policemen; porters; restaurant, hotel, and laundry workers; and physicians, nurses, and hospital employees. They are the people who are most liable to be infected by a sick traveler and to spread smallpox into the community.

"It is our hope," Dr. Terry continued, "that local health departments and employee health services in port areas will cooperate with the medical officers in charge of our quarantine stations in carrying out a voluntary, continuing program of smallpox vaccinations for these high-risk groups.

CLINICOPATHOLOGIC CONFERENCE *continued from page 439*

4. Nickerson, D. A.: Amniotic fluid embolism, J.A.M.A. 178:758–759 (Nov 18) 1961.
5. Clinical Section: Management of obstetrical patient with hemorrhage due to acute or subacute defibrination syndrome, L. M. Tocantins, M. D., Editor; Blood 14:1354–1367 (Dec) 1959.

THE PRESIDENT'S PAGE . . .

HOSPITAL RELATIONS . . . MEDICAL EDUCATION

■ AN ADDRESS delivered by John J. Flanagan, S.J., executive director of the Catholic Hospital Association, at a dinner of the Medical Staff, Divine Providence Hospital, Williamsport, Pa., in May 1963 is likely to be both interesting and challenging. He first called attention to the fact that there is no other activity like a hospital. It is a "*private* institution affiliated with an organized group engaged in private enterprise. The one is a voluntary health institution; the other, a rather informally organized group of private practitioners of medicine who voluntarily associate themselves with the hospital and do much of their work in the hospital. This represents a cooperative effort directed to the welfare of the citizens of a community."

He also pointed out that, historically, this represents one of the most significant developments in health care. Also, he said the American people are the chief benefactors of a type of care which cannot be paralleled in any country in the world.

His discussion concerned itself with the "preservation and continuation of the kind of medical and hospital care which we appreciate so much." He disregarded the threats which he considered as external, and directed emphasis to the "weaknesses that are internal and which, if not corrected, can weaken the fabric of our private endeavors and lead to the ultimate dissolution of our system."

In consideration of the relationships between hospitals and physicians, he states that, "Each group is, to a great extent, *suffering from success* and from too much professional self-satisfaction. Each takes the existence of the other for granted—and each is inclined to measure its importance at the expense of the other. Together, both represent a magnificent professional activity and service. Separated, each would dwindle into insignificance—the one to become a mere nursing home; the other, to revert to a disorganized and haphazard practice of home and office medicine. *It behooves both, therefore, to make special efforts to understand each other and to think of mutual support rather than any appearance of distrust or opposition.*"

He urges a sharing of information and a sharing of objectives. He recognizes that busy practitioners know very little about hospitals, and that governing boards and administrators have failed to communicate to their medical men and to the public the significant facts and features of hospital operations. He asks, "What does it mean to keep the hospital

Quoted from the LINACRE QUARTERLY, November 1963.

continued on page 443

NEW BOOKLET—OCCUPATIONAL HEALTH BOOKSHELF

To provide a comprehensive reading list for physicians who desire to increase their knowledge of occupational health and its various disciplines, the Industrial Medical Association, in collaboration with the Division of Occupational Health of the U. S. Public Health Service, has issued a new booklet called "Occupational Health Bookshelf."

The "Bookshelf" contains a total of 182 references which are listed under the following headings: General Interest and Historical Background; Occupational Disease and Disability; Special Health Problems; Industrial Hygiene and Toxicology; Employee Health Programs, Personnel and Facilities; Preventive and Emergency Services; Disability Evaluation, Rehabilitation and Compensation; and Supplemental Bibliographies. Professional periodicals in the field of occupational health are also listed.

From the total list of references, 13 are designated as the most important basic references in the field of occupational health. The references that appear in this list were selected by a committee of the Industrial Medical Association including Drs. R. E. Eckardt, chairman, J. S. Felton, David H. Goldstein, E. V. Henson, Charles E. Lewis, Hallett A. Lewis, Harold J. Magnuson and Arthur J. Vorwald.

Single copies of the "Occupational Health Bookshelf" will be sent without charge if request is accompanied by a self-addressed envelope with 10¢ postage affixed (a #10 envelope, or a 9 x 12 inch size). Requests should be addressed to the Industrial Medical Association, 55 East Washington, Chicago 2, Ill. Quantity prices will be supplied on request.

PRESIDENT'S PAGE *continued from page 442*

staffed three shifts a day, seven days a week? These figures can be staggering."

"Hospital administrators frequently fail to understand the problem of the physicians and the frustrations they sometimes experience in attempting to practice the best possible medicine in the hospitals. . . . Some administrators lean too heavily for advice on the wrong doctors—the gladhanders.

"Another barrier to general improvement in medical care is the nasty interprofessional bickering. This includes the bickering and petty competition between the specialties, *but most of all the devastating feud between specialists and general practitioners*, . . . confuses and dismays the lay person and undermines the prestige of the profession. *It would take a Solomon to judge where the greatest blame belongs.*"

The address contains some rather brash comments about general practitioners—which I believe would be wiser for me to hold for some future oral discussion. The section on medical education and the hospital will also be saved for a future report.

In closing his address, a plea was made for a "sustaining core." He states that if only a handful band together to make a start, and if they can mutually encourage and sustain each other, a core will be established.

"From this small group will emanate a spirit of search for professional excellence which will grow. If the organized hospital staffs of the community, the county medical society and the administration and governing boards of the hospitals unite in the one common and sacred purpose of serving the sick with all their resources and talents, they will have strengthened themselves in the best possible manner to protect our great system of medical care."

W. J. Egan M.D.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

NOVEMBER 1963
Vol. 62 No. 11

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Kerr-Mills Challenge

■ WISCONSIN'S PROGRAM for medical assistance to the aged under the Kerr–Mills Act should begin to operate in July of next year. The state's "Health Assistance Payments Act" (HAPA), which provides Wisconsin's share of the funds, also details the mechanics of the program, including eligibility and delegation of responsibility.

Generally, the HAPA program is a reasonable arrangement which should provide adequate medical care to the aged, who require it, in a dignified, discreet manner. Its benefits are generous, and if the funds are adequate to the case load, it should accomplish all that its supporters hope for it.

The State Medical Society has already organized Wisconsin Health Service to help in the administration of the HAPA program if we should be asked to do so. This step was taken in recognition of the great stake that our profession has in the successful implementation of the Kerr–Mills approach to health care for the aged. If it proves successful, the advocates of tax-supported medicine through the Social Security program will have their guns effectively spiked. As a profession we have supported the Kerr–Mills Act in preference to the social security approach, and in Wisconsin, under the HAPA program, we have a good chance to set a shining example of how a sensible medical care program should work.

One of the provisions of the Health Assistance Payments Act is the delegation of the administration of the benefits available under the program on a contract basis to either a private insurance company licensed to do business in the state or to a non-profit organization, such as Blue Cross or Blue Shield.

The State Medical Society has already announced willingness to undertake the administration of HAPA, and it is to be hoped that the contract will be awarded to this non-profit service sponsored by Wisconsin doctors. Unlike private insuring agencies, Wisconsin Health Service can provide the administration the HAPA program requires without adding a return-on-investment cost to the price of the service.

The final decision will be made by the State Department of Public Welfare. If it takes into consideration the element of qualification, as demanded by the law, as well as economy and the determination to make the HAPA program outstandingly successful, and it would be hard to do otherwise than to award the contract for administration of benefits to Wisconsin Health Service.

—D.N.G.

Remember the Good

NOW THAT the Great Krebiozen Hassle is over, we can marvel, in retrospect, at the role played by Dr. Andrew C. Ivy. Without Doctor Ivy's prestige as a respected scientist Krebiozen would probably never have attained anything more than the status of another false "cure." His endorsement meant so much that the movement to establish it as a legitimate therapy received not only wide popular support but even legislative interest.

From the start Krebiozen had all the classic earmarks that immediately identify a quack promotion: its formula was a secret; its rationale was unexplained and not subjected to independent verification; its "inventor" claimed the medical profession was in conspiracy against it; it was introduced to the public in the popular press without prior presentation through scientific channels. Despite these indications, Doctor Ivy chose to espouse Krebiozen vigorously and publicly. His decision cost him his job at the University of Illinois and separated him from the scientific community of which he had been a leading light.

Doctor Ivy is still crying foul at the decision of the Food and Drug Administration banning Krebiozen from interstate shipment and he continues to heap scorn on the National Cancer Institute for having insisted on a truly scientific test of the substance. His protests now, however, have the sound of a waning wind, and his brave stand against the truth of the matter is the pitiable posture of a man who doesn't know when he's lost the fight.

Why Doctor Ivy undertook the cause of Krebiozen will probably never be known. All we can do is conjecture. That he had the courage of his conviction—if it was a conviction—cannot be doubted in view of the fact that he laid his career on the line.

His career as a medical scientist is probably ended now, and more's the pity. Doctor Ivy's contribution to the advancement of medical science is a glorious page in the history of our profession. His tenure as dean of the school of medicine at the University of Illinois was a credit to that institution.

Dr. Andrew C. Ivy is a brilliant man. American medical science has been greatly advanced by his work. Let us remember him for his contributions, which are fundamental and long-lasting, not for the puzzling position he assumed in the unfortunate Krebiozen episode.—D.N.G.

AMERICAN COLLEGE OF ALLERGISTS

The American College of Allergists Graduate Instructional Course and Twentieth Annual Congress will be held March 1–6, 1964, at the Americana Hotel, Bal Harbour, Miami Beach, Fla. For further information write: John D. Gillaspie, M.D., Treasurer, 2141 14th Street, Boulder, Colo.

AMERICAN INDUSTRIAL HEALTH CONFERENCE

The 1964 American Industrial Health Conference will be held April 13–16 at the Pittsburgh-Hilton Hotel in Pittsburgh, Pa., it has been announced by the Industrial Medical Association and the American Association of Industrial Nurses. This medical-nursing Conference which is comprised of the annual meetings of the two sponsoring Associations, will bring together approximately 2,000 persons which, in addition to industrial physicians and nurses, will include industrial hygienists, safety engineers, public health officials, military service medical personnel, university faculty members, management representatives and others who have an interest in the health of the working population.

The scientific program, in which many of the nation's experts in the field of occupational health will participate, will be augmented by both scientific and technical exhibits. Intensive courses in selected areas of medical practice and industrial hygiene also will be presented. Further information about the Conference may be obtained by writing American Industrial Health Conference, 55 East Washington St., Chicago, Ill. 60602.

SPECIAL TO THE JOURNAL

Eulogy to a Small Town Country Doctor

By ROSE ANN MURPHY, Lansing, Iowa

EDITOR'S NOTE: A small community in Iowa recently honored its beloved physician earlier this year by having a day of festivities dedicated to DOCTOR JOHN. Similar programs honoring the "country doctor" have been held throughout the country and have become a symbol of "bygone days" in medicine. Included in the program honoring Dr. John W. Thornton of Lansing was the reading of a winning essay by Rose Ann Murphy, a college student, who eulogized the life of a small town country doctor. Dr. James C. Fox of La Crosse also was a speaker. The essay follows, with the permission of Miss Murphy.

PRAISE AND admiration to a fellowman after a lifetime of unselfish service were the thoughts of the day when hundreds of friends, relatives, and associates gathered together one Sunday afternoon to honor Dr. John Thornton. The high esteem in which the doctor is held in his community was ably expressed by several speakers at the special occasion. Dr. James C. Fox, La Crosse, spoke for area physicians and told of the esteem in which he was held at La Crosse hospitals and in what regard all his diagnoses and opinions were held by the doctors and governing boards. His judgment and criticisms seemed always to be correct. Another speaker brought out that Doctor Thornton was a football player and ever since college days an avid fan as well as an expert bridge player. Mayor George W. Trayer spoke for the townsfolk with praise for his untiring community spirit and activities. Monsignor Henry Scharphaff spoke of the silent, courteous, and courageous man he has known for the past 20 years who like no other braved all conditions to make a professional call no matter where or when he was needed.

■ TODAY I want to speak to you about a man indispensable to the small community; one with inexhaustible patience and with an insight into human life and human problems; the one man whom constant contact with suffering has mellowed, not embittered; a man whose life seems to belong to everyone, because it has been dedicated to everyone's welfare; yet whose very intimacy with all families puts him above and beyond a small town's functions and gossip. Who is this man? He is the fast disappearing and unsung hero of rural communities—

The Local Country Doctor

Modern mechanization and cross plans of various colors have not reduced the hazards inherent in everyday living. A sudden fever or a choking spell still terrorizes the young mother, alone except for the telephone which links her with the local doctor. Be it the ailing grandparent stricken swiftly; the treacherous fall; or the unforeseen accidents of a dozen types possible in and about a farm; be the victim eight or eighty—the refrain is the same: "Call Doctor John, he'll know what to do."

Yes, he'll know what to do, for he has spent many years in study and preparation. He has sacrificed yet more in terms of opportunities for advancement when he determined to remain with us—the people of the small home towns of the nation.

Who knows what prominence he would have achieved? Who can tell the stir his name might have created in medical circles had he not decided to remain obscure. And decide he did; for it is an evident fact that many a small town doctor has been urged to join name clinics and has declined. Take this example from my own experience: A relative of mine consulted our local doctor who gave her a diagnosis but suggested that for her own satisfaction she spend some time in a distinguished clinic. After a week of x-rays, blood tests and examinations, the diagnosis was identical. "Why, my doctor back home told me the same thing," she gasped.

"No doubt your x-rays showed it," the specialist answered. The lady looked at him sharply, and replied, "But he took no x-rays, Doctor." "All I can say then is," the man murmured, "What is he doing in such a God-forsaken place?"

What is he doing? He has brought hundreds of new lives into this world; he has saved countless other lives by his promptitude and his skill in diagnosis, he has brought hope and alleviation to scores of isolated sufferers who find hospitalization impossible. He has been

"All Things to All Men"

and has lived his life "by the side of the road where the race of men go by." That's what he has done

Miss Murphy was a junior at St. George High School, Lansing, when she wrote the eulogy. She presently is a junior at St. Louis University. Her parents are Mr. and Mrs. Cyril Murphy of Lansing, Iowa.

in this place—that's what others are doing in small towns, nor are these towns God-forsaken. In fact as long as there are "Doctor Johns" among us, God is very much on our side.

Yet, so often we do not sufficiently appreciate this friend in our midst. As the poet has humorously said:

"Three faces wears the doctor; when first sought
An Angel's; and a God's, the cure half wrought;
But when the cure complete, he seeks his fee,
The Devil looks less terrible than he."

Yes, there is the perennial problem of collecting bills. True, money does not come first with him, or he wouldn't be with us. After he has alleviated pain and suffering, he always is willing to "let the bill go till later." How often this "later" never comes, as people attend to other more insistent creditors first and forget their greatest benefactor in real need!

Still, in fair weather or storm, by day or by night, on week day or holiday, the rural doctor is at our beck and call. His time is ours; he has no substitute. Without a schedule we can call regularly, his ear is ever attuned to the urgency of that telephone ring, to the apathetic walk or gentle moan of the sick in his office. These come first; his needs: food and rest—are secondary. We in our town have seen this miracle:

The Perfectly Selfless Man for Almost Fifty Years

He moves among us, an expert in his religious and civic duties as he is in his medical practice.

How many like him do we find in this our day? Will there come a time when this kind will have become extinct? Who is there today willing to take the place of these stouthearted men? Too often the appeal to an easier life, a more lucrative and more promising career is too compelling for our younger men.

But surely there are among the younger generation some few who will have the courage to face the life of self-dedication demanded of the country doctor—to give of their knowledge to those who otherwise will be unserved. Someone must answer the summons that comes from the rural hamlets and towns dotting the countryside—a summons to follow in the footsteps of these men—like our DOCTOR JOHN, of whom it may be truly said,

"Beloved of God and Man"

GOOD WAY TO IMPROVE PUBLIC RELATIONS . . . COMMENTS FROM THE PRESS

Development of a standard casualty medical report for use by doctors and the insurance claim fraternity in Wisconsin should go a long way to remove an irritant that has been the subject of continuous and widespread criticism of the insurance business by the medical profession for years. The form is clear, simple, understandable, and easy to type.

We suspect that some of the irritation expressed over the years by the doctors has been echoed by patients. Consequently, there is involved a good deal more of the public (and the relations of the insurance business with it) than just the medical men.

Others will echo the sentiment of the Wisconsin doctors when they say that "it is the hope of the society that by continuing to work with the insurance industry, standard forms will be developed for other lines of insurance. Accomplishment of this end will reduce the paper work of the physician while still giving insurance companies the medical information they need."

This looks like one of the best pieces of good public relations that has been accomplished in some time.—Reprinted from *The National Underwriter*, Oct. 11, 1963.

Interim Meeting

House of Delegates

October 18 and 19, 1963, State Medical Society Headquarters, Madison

The first Interim Meeting of the House of Delegates was held October 18–19 at the State Medical Society headquarters in Madison. Subjects before the House included a report from the committee appointed to study the management survey report (including its recommendation on the Blue Shield Plans), Kerr–Mills implementation in Wisconsin, 1964 dues, relationships with welfare departments, scientific teaching programs, legislation and reports from a number of Society committees.

Blue Shield Plans

Subject of considerable debate during the meeting was a resolution dealing with relationships between the two Blue Shield Plans in the state. The Booz, Allen & Hamilton report, presented to the House in May, had recommended merger of the two plans; the committee appointed to study the report submitted a resolution rejecting this as "impractical and untimely." The final action of the House was as follows:

> "*Resolved*, that Wisconsin Physicians Service, the Blue Shield Plan of the State Medical Society of Wisconsin, and Surgical Care, the Blue Shield Plan of the Medical Society of Milwaukee County, continue to operate independently under their present structure and that each operate throughout the state under fair competition, and
>
> "*Be It Further Resolved*, that the Survey Committee be instructed to prepare a more detailed analysis of that portion of the Booz, Allen & Hamilton report having to do with reorganization of the Blue Shield Plans for submission to the next meeting of the House of Delegates."

Resolutions

Sixteen resolutions were considered by the House. The first four originated with county medical societies, the next ten were submitted by the Survey Committee which considered the Booz, Allen & Hamilton report, and the last two dealt with the Health Assistance Payments Act (HAPA), which implements Kerr-Mills in Wisconsin.

RESOLUTION No. 1—Dealing with various matters involved in relationships with the State Welfare Department, referred to the Council for further study, with the results to be reported at the next meeting of the House.

RESOLUTION No. 2—Asking the Society to investigate the feasibility of offering a comprehensive insurance coverage to the State of Wisconsin applicable to the medical care of welfare and relief recipients, referred to the Council for further study, with the results to be reported at the next meeting of the House.

RESOLUTION No. 3—Asking the Society and its AMA delegates to further expedite efforts to standardize insurance reports of all kinds, approved.

RESOLUTION No. 4—Inviting the Society to hold its 1965 or 1966 annual meeting in La Crosse, rejected as impractical, at this time.

RESOLUTION NO. 5—To amend the Bylaws calling for one interim session of the House each year, introduced for action next May.

RESOLUTION No. 6—That the House, at its Fall Meeting, receive, consider and act upon the programs of the Society and their supporting budgets for the ensuing year, approved.

RESOLUTION No. 7—That the fiscal year of all organizations of the Society commence on January 1 and extend through December 31, approved.

RESOLUTION No. 8—That the Council receive annual reports and recommendations for new programs from the chairmen of all committees sufficiently in advance of the Fall Meeting to permit the program planning and budget committees to make accurate appraisals and recommendations to the House prior to the Fall Meeting, approved.

RESOLUTION No. 9—That all appointments to committees of the Council shall be made at the organizational meeting which shall be held immediately following the annual meeting, approved.

RESOLUTION No. 10—That reports of all committees be available to the Council at least six weeks before the meeting of the House to which they are to be submitted, approved.

RESOLUTION No. 11—Dealing with reimbursement of members for expenses incurred in attending meetings of the Society, referred to the Council for establishment of a policy to be reported for action at the next meeting of the House.

RESOLUTION No. 12—Dealing with relationships of the Blue Shield Plans, action taken as outlined earlier in this report.

RESOLUTION No. 13—Amending the Constitution so that special sessions of the House may be called by the Speaker on written request of 20 delegates representing 10 per cent or more of the component county medical societies, acknowledged and recommended for presentation at the annual meeting in May.

RESOLUTION No. 14—Creating the position of Historian, referred back to the Survey Committee for fiscal note and resubmission to the House at the next meeting.

RESOLUTION No. 15—Commending the Legislature and Governor for bi-partisan support in implementing the Kerr-Mills program of medical assistance for the aging in Wisconsin, approved.

RESOLUTION No. 16—Expanding the Wisconsin Health Service, a unit of the Society which is eligible for selection to administer the benefits of the Health Assistance Payments Act (HAPA), implementing Kerr-Mills, to include representatives of allied and ancillary professions, approved.

Survey Study Committee

In addition to the ten resolutions (5 through 14) outlined above, the committee authorized to review and study the Booz, Allen & Hamilton report filed a plan of action and outline of general recommendations with the House and asked to be continued for another year.

The House continued the committee for a year and invited specific resolutions concerning the additional recommendations filed.

Bylaw Amendments

Three amendments to the Bylaws were forwarded by the Council, and recommended for submission at the annual meeting next May:

1. To allow the Council to extend the privileges of membership to non-physician teachers of the basic sciences as "Scientific Fellows." They would be eligible to attend scientific meetings and receive the *Wisconsin Medical Journal,* but would not vote, hold office, or pay dues.
2. To provide that a model county medical society constitution and bylaws, recently adopted by the Council, would apply where a county society had lost or misplaced its own.
3. Enlargement of the Commission on Public Policy to include seven representatives of the membership at large, a representative from each scientific section of the Society, and the president, president-elect, and secretary.

Legislative Policies

With the Legislature returning November 4 and many health bills pending, the House took the following actions:

1. Favored voluntary efforts in area hospital planning and opposed any legislation which would make it mandatory that a governmental agency be responsible for the franchising of new or expanded hospital facilities.
2. Opposed Bill 134, A., which would attempt to equate optometrists with the profession of medicine in respect to services performed and reimbursement of these services.

SLIGHTLY MORE THAN 75 per cent of the total number of elected delegates registered for the Interim Session of the House of Delegates meeting at the State Medical Society headquarters in Madison for the first time. Some of the delegates are shown above in the Presidents' Room which is in the newly completed west wing of the Society building. Dr. D. J. Twohig of Fond du Lac appears in the center of the picture as he presents a recommendation to the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws. In the background can be seen five of the diaramas given to the CES Foundation by the American Medical Association. The diaramas, which depict great moments in the development of medicine, were displayed this summer at the Museum of Medical Progress at Prairie du Chien.

3. Opposed Bill 420, A., which would give podiatrists the unrestricted right to prescribe, dispense and use narcotic drugs.
4. Supported Bill 107, S., to add bacteriology, biochemistry and hygiene to the subjects covered in the basic science examinations.
5. Opposed Bills 627, A., and 628, A., which would subject all Blue Plans to detailed regulations by the insurance commissioner, including the settling of rates.
6. Recommended that the Legislature should take no decisive steps in revision of the Mental Health Act without thorough and detailed analysis by appropriate committees or advisory groups.
7. Supported Bill 300, A., permitting private insurance carriers and Blue Plans to use a pooling mechanism for offering voluntary major illness insurance for the elderly.
8. Opposed Bill 568, A., which would require chiropractors to use the term "Doctor of Chiropractic," or the letters "D.C." provided the letters are accompanied by the word chiropractor.

Wisconsin Physicians Service

The House approved a report by the Commission on Medical Care Plans, including the following information on WPS:

--- anticipated premium income of more than $13 million for 1963.

--- present contract count of over 200,000, including 1,700 for the new Prescription Drug coverage and over 12,000 for the Century Plan for persons over age 65.

--- reserves, at the end of July, of nearly $2.5 million, with anticipated total reserves at the end of 1963 of nearly $3 million.

Other Actions

1. Set the annual dues for 1964 at $90, unchanged from last year.
2. Approved a number of scientific teaching programs:

   --- a series of half-day instructional courses, primarily for general practitioners, in cooperation with the University of Wisconsin Medical School.

   --- a series of five one-day programs, in cooperation with the Wisconsin Academy of General Practice.

   --- a series of experimental telecasts of scientific teaching programs during "off hours" over educational television stations in Madison and Milwaukee, with kinescopes available for use in other areas of the state.

   --- a pilot program where "visiting professors" from the medical school faculties would spend a day in selected hospitals for "rounds," consultation, and informal presentations.

3. Approved annual writing awards for Wisconsin authors of scientific papers in the *Wisconsin Medical Journal.*
4. Urged cooperation by county medical societies in local programs for the aging and in developing community activity in promotion of voluntary services for the elderly.
5. Received a report on out-of-state meetings of Society bodies and stated that these should be continued as long as they are in the best interests of the Society.
6. Encouraged each county medical society to have an interested and active liaison with its county welfare department, and stated that welfare problems are best solved at the local level, with referral to the state level when local efforts fail.
7. Commended the Executive Committee of the Charitable, Educational and Scientific Foundation for projects it has fostered and completed, and encouraged physician participation and support for Foundation work.
8. Authorized the Council to study the organization, membership qualifications and other details of the scientific sections of the Society.
9. Approved development of a medical photography display at the annual meeting, with both scientific and nonscientific categories.

UNIVERSITY OF WISCONSIN SPEECH AND HEARING CLINIC

The University of Wisconsin Speech and Hearing Clinic is now located under one roof at 905 University Ave., Madison. Launched in 1914 by Dr. Smiley Blanton, the UW clinic was the first to be established on any college campus. In 1959 the installation was combined with the Community Chest-sponsored Hear, Inc., and a Rehabilitation Center was set up in a temporary building on Linden Drive.

Anyone from the state of Wisconsin is eligible for help in the clinic. Patients are sent by family doctors, city and county speech correctionists, public health nurses, and teachers. Clients pay for services according to their financial circumstances. Welfare agencies help those without funds. More than 560 persons took advantage of the services last year. Dr. John V. Irwin is the present director.

In addition to support from United Givers, the clinic receives funds from the U. S. Vocational Rehabilitation Administration and the National Institutes of Health to train graduate students.

TRANSACTIONS OF 1963 REGULAR SESSION HOUSE OF DELEGATES

State Medical Society of Wisconsin

MAY 6, 7 and 8, 1963

TABLE OF CONTENTS

Announcement of Reference Committee Appointments ---- 452

Minutes of 1962 Sessions Approved ---- 452

Reports of Officers ---- 452
- Report of President ---- 452
- Report of President-elect ---- 454
- President-elect Committee Appointments ---- 454
- Report of Council ---- 454
- Supplementary Report of Council ---- 459
- Report of Treasurer ---- 464
- Report of Secretary ---- 465

Report of Committee on Health Economics of American Life (HEAL) ---- 469

Report of the Commission on Public Policy ---- 470

Report of State Health Officer ---- 472

Report of State Board of Medical Examiners 473

Report of the Division on Chest Diseases ---- 473

Report of the Division on Handicapped Children ---- 475

Report of the Division on Maternal and Child Welfare ---- 476

Report of the Division on Nervous and Mental Diseases ---- 478

Report of the Division on School Health ---- 479

Report of the Division on Visual and Hearing Defects ---- 479

Report of the Commission on Scientific Medicine ---- 480

Report of the Committee on Disaster Medical Care ---- 481

Introduction of Resolutions ---- 481

Remarks of the President of the Woman's Auxiliary to the State Medical Society ---- 483

Remarks of A. M. A. Delegate ---- 483

Resolution No. 1 ---- 485

Resolution No. 3 ---- 486

Resolution No. 4 ---- 486

Resolution No. 5 ---- 486

Resolution No. 6 ---- 486

Resolution No. 7 ---- 487

1962 Annual Report of the Commission on Medical Care Plans ---- 488

1964 Dues ---- 490

Extraordinary Session ---- 490

Remarks of the Secretary ---- 490

Committee on Nominations ---- 491

Introduction of Resolution ---- 491

Report of Committee on Nominations ---- 491

Election of Councilors ---- 491

Site of 1964 Annual Meeting ---- 491

Resolution of Appreciation ---- 491

Remarks of Secretary ---- 491

Committee on Credentials ---- 491

ATTENDANCE AT HOUSE OF DELEGATES ---- 492

TRANSACTIONS OF 1963 REGULAR SESSION, HOUSE OF DELEGATES

State Medical Society of Wisconsin May 6, 7 and 8, 1963

The 122nd annual meeting of the House of Delegates of the State Medical Society of Wisconsin was held at the Hotel Schroeder, Milwaukee, Wisconsin, on May 6, 7 and 8, 1963. Dr. Robert E. Callan, Speaker of the House of Delegates, presided.

Presented below are reports submittted to the House, the recommendations by reference committees and the House actions.

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

J. F. Walsh, M.D., Port Washington, Chrm.
L. W. Schrank, M.D., Waupun
H. W. Twelmeyer, M.D., Milwaukee
F. M. Hilpert, M.D., Racine
C. J. Strang, M.D., Barron

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

F. E. Gehin, M.D., Stevens Point, Chrm.
J. E. Martin, M.D., Delavan
G. W. Hilliard, M.D., Milwaukee
W. T. Russell, M.D., Sun Prairie
J. V. Bolger, Jr., M.D., Waukesha

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

C. J. Picard, M.D., Superior, Chrm.
C. W. Stoops, M.D., Madison
R. F. Purtell, M.D., Milwaukee
L. E. Fazen, M.D., Racine
G. A. Behnke, M.D., Kaukauna
D. R. Griffith, M.D., Eau Claire
E. P. Rohde, M.D., Galesville

■ MINUTES OF 1962 SESSION OF HOUSE

The entire proceedings of the 1962 regular session of the House were printed in the September 1962 issue of the *Wisconsin Medical Journal*, beginning at page 457.

HOUSE OF DELEGATES ACTION—Approved as printed.

■ REPORT OF PRESIDENT—1962–1963

Nels A. Hill, M.D., Madison

Since my election as President of the State Medical Society of Wisconsin, it has been my aim to represent the best interests of the Society. I have considered it an honor and a duty to reflect the ideas of the individual members of the Society. To increase my knowledge and comprehension of medical affairs I have attempted to attend all the committee and commission meetings that I possibly could. This year has been relatively free from storm and controversy, but there has been curiosity, tension, and a sense of expectancy about the long-awaited management survey.

I have spent much time in pursuing this survey and I find it too long, too complicated, and possibly too controversial to be completely digested at this meeting. Therefore, I recommend that it be received, taken home, and studied in a diligent manner. At a later date, possibly in the fall, it can be reconsidered in a thoughtful manner, without emotion.

This report involves the reputation of the doctors of Wisconsin and their Society. We are all interested in not only preserving but also in improving our services to the public. It behooves us all in our present situation to give this report deliberate and thoughtful consideration. We must strive to consider the implications of the entire report before any action is taken. I am sure the members will be motivated by what is best for the Society.

The staff should be asked and offered the opportunity to supply the material to fill in the gaps that are evident in the survey report; otherwise, there will not be a foundation for a sound evaluation of the report.

By now, you sense that I do not like the report with its omissions and inadequacies. Therefore, I further recommend that a comprehensive and fully representative committee from the House of Delegates, the Council and the present survey committee study the situation before any more money is spent for so little value.

Over the past two years, the opportunity to visit the annual meetings in our neighboring states, the North Central Conference and the two sessions yearly of the AMA, has demonstrated to me that our State Society is one of the strongest and most successful in the nation.

Projects pioneered here have been followed or adopted in other states because of the vision, wisdom, and energy of our staff and members. This enviable position that we have established is one of the intangibles that cannot or has not been measured by the management survey. It is the result of many man-hours of devoted and dedicated effort by all of us.

There have been several notable events and accomplishments this past year.

We have made some progress in developing simplified insurance forms . . . a short and simple casualty reporting form has been developed, approved by the Council and is now available without cost to every doctor in our state. But this is only a beginning, for insurance forms are multiplying at a faster rate than ever before. Not only are multiple lines of insurance increasing, but almost every hospital, clinic and county society is developing its own insurance forms. It would appear logical that these forms follow the same order as the customary physical examination, beginning at the head and proceeding down over the body.

Our legislative activities have been varied and difficult, ranging from meetings of HEAL in Los Angeles and Chicago to appearances before legislative committees. On the national scene, we will be concerned with King–Anderson type legislation, the Hospital Insurance Act of 1963. It is vital that every member be informed and reach the public intelligently and effectively. The cost of medical care is almost an obsession with our legislators. I sincerely believe every doctor should make clear to his patients and others that our concern is with the quality of medical care and the resulting good health of our patients. Concern for cost must not be allowed to cheapen and reduce the quality of medical care as it has elsewhere in the world. We can be more convincing in our own communities than the most fluent national speakers and writers.

As a resident of Madison it has been my privilege to meet with the Dane County Board and the City Council of Madison as a member of the Westside Business Men's Association. This January, the State Chamber of Commerce held a reception for the Legislature and elected State Society Officers, that I also attended. Since most Presidents and State Medical Society Officers are not residents of Madison, it seems logical that a reception be held annually or biennially to give our officers an opportunity to meet elected state officials, legislators and University authorities to continue the best possible

relations and to provide accurate information on medical issues to our elected officials.

At a recent visit to the Iowa State Medical Society, Kerr–Mills legislation had just been approved by their Senate by a vote of 48 to 0. We have a draft of such legislation in Wisconsin and hope you will press for its passage.

Chiropractic legislation is a biennial problem. An intramural fight between chiropractors enlivens the present session. Again this year they are repeating their efforts to be doctors by legislative permit. Almost daily other bills of medical interest appear on the calendar and need specialized evaluation and interpretation.

We have had two very well-publicized and attended conferences . . . The Work Week of Health, and the Conference on Health Fads and Fallacies. At the Work Week of Health, we were honored by the presence of the Presidents of Illinois, Iowa, Michigan, and Minnesota and by many outstanding speakers of national importance. We are still receiving complimentary comments.

This meeting served to dedicate the new West Wing completed last October. We now have adequate meeting room—the President's Room—for meetings of this type and also of the House of Delegates.

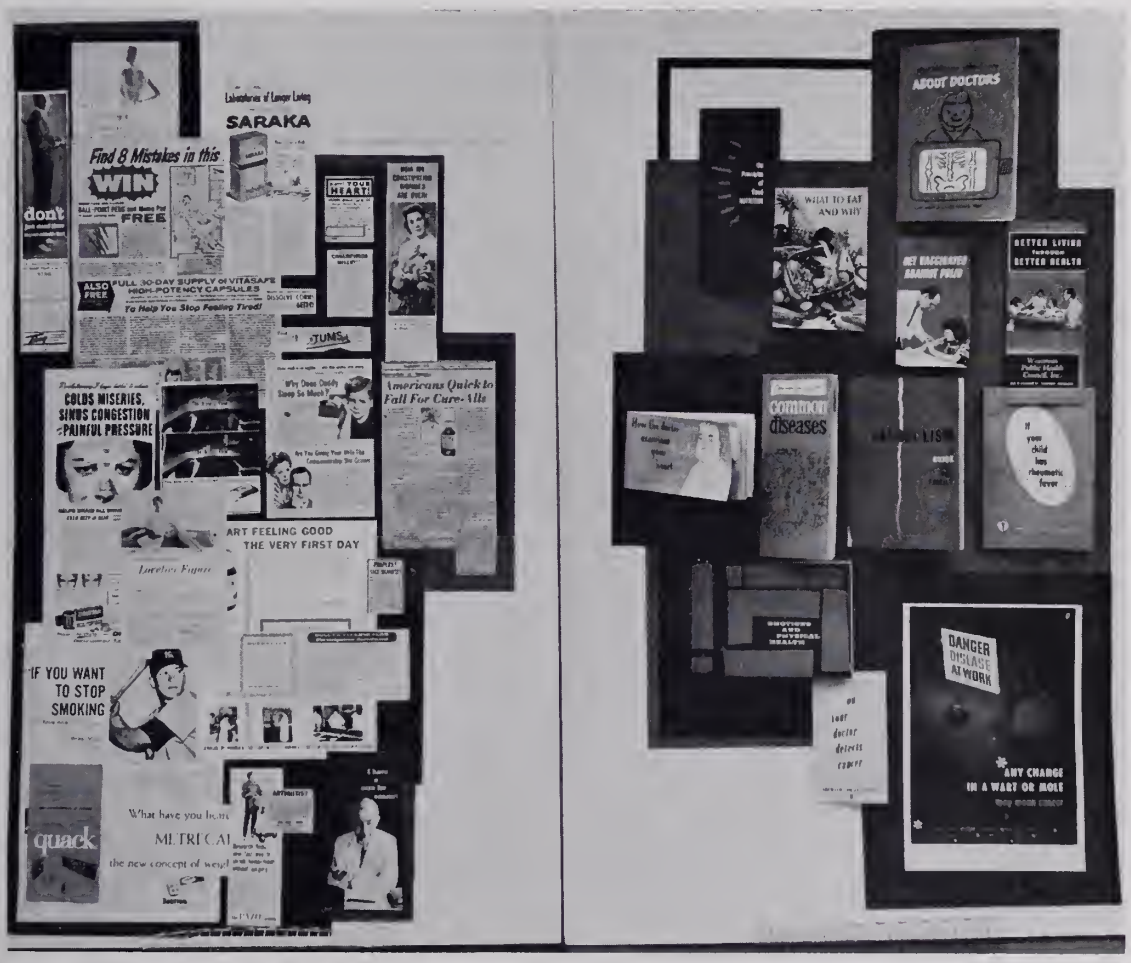
The Conference on Health Fads and Fallacies served to expose quackery in all its varied forms. We can only hope that educational programs of this type will reach some of the public who have been victims.

In addition to all of this planned activity, an unexpected visit from a group of 75 Rural French Physicians and their wives, enlivened our schedule. In a whirlwind visit of a day's duration, we showed them our SMS Building, had a closed circuit TV operation demonstration, took them to visit clinics and offices, lunched with them and even addressed them in French . . . only a few understood English.

The wives were entertained by our Auxiliary and we are sure this is one way to increase understanding of mutual problems between countries.

My favorite project of the Medical Society is the CES Foundation and its varied activities. The Museum in particular with its exhibits from the past and the present, can teach us as a profession, and also the public. The Stovall Hall, dedicated in the summer, drew an audience from several states and will provide enlarged exhibit facilities.

ONE OF THE DISPLAYS at the Conference on Health Fads and Fallacies showed the literature used in the promotion of health fads and fallacies on the left side and the literature used to expose quackery and to educate the public in sound medical practices on the right side.



We must continue our donations to the Foundation to insure funds for student loans and other educational demands.

This has been a rewarding experience for me. I have served you to the best of my ability and I leave you in the good hands of my successor . . . Dr. William J. Egan.

PRESENTATION TO DOCTOR HILL

Robin Allin, M.D., Madison

As President of the Dane County Medical Society, Doctor Hill's grass roots society, it is my privilege on behalf of his colleagues to make this presentation to him.

For your many years of personifying the very best of personal physicians, for your many years of devotion to your local society, to the Third Councilor District, and more recently, for your own unselfish efforts on the part of the State Medical Society, as President-Elect, President, and now as Retired President, it is my privilege to present this token (a silver service tray with an engraved tribute) of our appreciation of your Dane County Doctors.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended adoption of the President's report. It paid tribute to Doctor Hill for his work during the past year and his part in helping further the ideas of Wisconsin medicine.

HOUSE OF DELEGATES ACTION—Adopted the report of the President as recommended by the Reference Committee.

■ REPORT OF PRESIDENT-ELECT—1962–1963

W. J. Egan, M.D., Milwaukee

The report of the President-elect was printed in the June 1963 issue of the *Wisconsin Medical Journal*, starting at page 241.

Under the provisions of the Bylaws, the President-elect appointed the following standing committee members where terms expired or vacancies occurred:

COMMITTEE ON CANCER

J. R. Hoon, M.D., Sheboygan (reappointed)
William Reed, M.D., Watertown
J. E. Dettman, M.D., Green Bay
Harold Guzzo, M.D., Washburn (appointed)
G. I. Uhrich, M.D., La Crosse (appointed as chairman)
G. A. Smiley, M.D., Delavan (vice-chairman)

COMMITTEE ON GRIEVANCES

J. D. Leahy, M.D., Park Falls (reappointed) (vice-chairman)
Melvin F. Huth, M.D., Baraboo
Donald R. Griffith, M.D., Eau Claire (appointed)
E. D. Sorenson, M.D., Elkhorn (reappointed as chairman)

COMMISSION ON PUBLIC POLICY

C. F. Broderick, M.D., Wisconsin Dells (appointed)
R. G. Zach, M.D., Monroe (reappointed as chairman)
W. T. Russell, M.D., Sun Prairie (vice-chairman)

COMMISSION ON SCIENTIFIC MEDICINE

T. V. Geppert, M.D., Madison (appointed)

COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION

H. G. Bayley, M.D., Beaver Dam
S. L. Henke, M.D., Eau Claire (reappointed)
P. C. Dietz, M.D., La Crosse (appointed)
R. S. Gearhart, M.D., Madison (reappointed as chairman)

COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS

D. E. Dorchester, M.D., Sturgeon Bay (reappointed) (chairman)
J. E. Martin, M.D., Delavan
R. J. Botham, M.D., Madison (reappointed) (vice-chairman)

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended adoption of President-elect's report, including committee appointments.

It noted the fact that he had attended many meetings which should enable him to give invaluable service to the Society in the coming year. It also noted his emphasis on the fact that the House of Delegates is the supreme legislative body of the Society. It emphasized, at Doctor Egan's suggestion, the importance of all members participating in the activities of the State Medical Society as well as those of their county medical societies.

HOUSE OF DELEGATES ACTION—Adopted the report of the President-elect as recommended by the Reference Committee and approved the committee appointments.

■ REPORT OF COUNCIL—1962–1963

James C. Fox, M.D., La Crosse, Chairman

Members of the Council are committed to four regular meetings a year, generally involving two days, and quite often one or more special meetings of the Council. In addition to participation in these meetings, each councilor is assigned to a committee of the Council which has the function of screening and detailed study of projects coming before the Council or before the House of Delegates at some future date. Meetings of these committees of the Council plus attendance at the House of Delegates and certain other meetings which by necessity must be attended by representatives of the Council involve a very considerable work load. Since May of 1962, the Council met in July, November, February, April, and will meet the Sunday preceding the first session of the House.

Osteopathy

One subject of major concern which consumed a very considerable amount of time both in the Planning Committee and before the Council proper is the general subject of osteopathy. Action finally taken at the February meeting of the Council was the adoption of the following statement, and members of the House are urged to communicate this material back to their county societies when they report on actions taken here:

"Voluntary professional relationships between a Doctor of Medicine and a Doctor of Osteopathy should not be deemed unethical if the county medical society determines that the Doctor of Osteopathy:

"(1) Is currently licensed to practice medicine and surgery under the Medical Practice Act of the State of Wisconsin.

"(2) Practices the healing art founded on the broad and all-inclusive principles of scientific medicine.

"(3) Submits himself and any hospital with which associated, if proprietary, to the same voluntary surveillance common to those hospitals which adhere to the principles of the Joint Commission on Accreditation of Hospitals.

"(4) Does not possess, in addition to his degree of Doctor of Osteopathy and Surgery, the degree of Doctor of Medicine obtained solely by the transfer of credits and not by resident enrollment in an approved medical school.

"(5) Comports himself according to the Principles of Medical Ethics as those Principles have been and will be applied or interpreted from time to time.

"The State Medical Society of Wisconsin, by and with the consent and advice of county medical societies, will encourage such doctors of osteopathy as meet these standards to attend appropriate programs of postgraduate education, and will meet with representatives of the Wisconsin Association of Osteopathic Physicians and Surgeons on matters of mutual interest from time to time."

Podiatry

The Insurance Commissioner in 1962, upon advice of the Attorney General, concluded that podiatrists were in effect physicians and surgeons to the extent they were permitted to provide treatment as might a physician himself. Thus the Insurance Commissioner argued that Wisconsin Physicians Service must recognize the services of podiatrists in any case where it would provide benefits for the services of a physician doing the same procedure. The Council authorized our attorneys to handle this matter in appropriate court proceedings to test the validity of the rule. John Kluwin, Esq., of Milwaukee, was designated "of counsel" and the matter is now in court with no decision at this time.

Members of the Society will be kept advised as this matter develops.

The Matter of Compulsory Certification or Licensure

In the February meeting the Council felt it advisable to adopt a formal statement with reference to this subject, due largely to the fact that there is much pending legislation in the field. This statement deserves the widest circulation and repetition, and it is felt that the delegates are in a good position to help in this respect.

"The tremendous development of medical sciences over the course of the last several decades in particular has brought about almost an explosive growth in the number of fields of special training ancillary to medicine. At the present time there are in the neighborhood of fifty categories of medical technicians. (See appended listing from a September 1959 survey prepared by the Law Division of the American Medical Association for the Committee to Study the Relationship of Medicine with Allied Health Professions and Services.)

"In Wisconsin there are licenses or certificates permitting limited practice in such varied fields as chiropody, physical therapy, professional nursing, and trained practical nursing.

"The question is presented from time to time, and exists at the present time, whether licensure or certification by the state is the most advisable process for establishing standards of education, examining credentials and abilities, and regulating the practice of such specially trained groups.

"The State Medical Society opposes the further extension of licensure, certification, or registration under Wisconsin law.

"Its reasons for doing so are:

"(1) A limited license seems to stimulate continuing efforts to expand the area of permitted practice without a corresponding expansion of training and qualifications.

"(2) Delegation to one holding a license or registration by the state may be argued as delegation of responsibility within the capacity of that individual to practice, where in fact, the responsibility of a physician and surgeon should be a matter of individual judgment on his part.

"(3) Licensure implies to the public skilled training and a right of freedom of practice within those skills, without necessarily defining the precise area of practice.

"These are among the more basic reasons. Others could be enumerated.

"The State Medical Society feels that the present program of voluntary certification, adaptable to the needs of the time, to the growth of the science, and particularly framed in light of practical considerations, will assure the public of a greater supply of these essential and valued assistants.

"However, the State Medical Society can at the best but express its views. Under some circumstances it might actively oppose state certification or licensing. It can not do other than bring its influence to bear, and that may at times be insufficient; or, indeed, the circumstances may arise where the Society would support such legislation.

"In any event, the Society believes that whatever legislation might conceivably be enacted in the future, these matters should be kept well in mind:

"(1) The group to be certified or licensed by the state should pay a sufficient amount for initial licensing and for annual registration as will assure the maintenance of proper records and the payment of a salary sufficient as to command administrative attention.

"(2) Any such legislation should have adequate provision for enforcement and should broadly outline proposals therefor.

"(3) Since such certification or licensure is ancillary to the field of medical practice, it would be proper and preferable that the board or committee be under the broad supervision of the State Board of Medical Examiners.

"(4) The fact of proposed enactment of such legislation should be widely known throughout the state so that persons to be affected by it may have ample opportunity to understand it and its application to them."

Appendix

Scientific, Professional and Technical Personnel in the Health Fields*

1. Anatomists
2. Audiologists
3. Basal metabolic technicians
4. Bioanalysts
5. Biochemists
6. Biophysicists
7. Biostatisticians
8. Chiropodists
9. Clinical chemists
10. Corrective therapists
11. Cyto-technologists
12. Dietitians
13. Electrocardiographic technicians
14. Electroencephalographic technicians
15. Electrologists
16. Epidemiologists
17. Histologic technicians
18. Hospital administrators
19. Industrial hygienists
20. Inhalation therapy technicians (Oxygen therapy technicians)
21. Lay psychoanalysts
22. Masseurs and mechano-therapists

23. Medical illustrators
24. Medical record librarians
    Medical record technicians
25. Medical social workers
26. Medical technologists
27. Microbiologists
    Bacteriologists
    Immuno-serologists
    Mycologists
    Parasitologists
    Virologists
28. Midwives
29. Music therapists
30. Nutritionists
31. Occupational therapists
32. Opticians
33. Optometrists
34. Orthoptic technicians
35. Pharmacists
36. Pharmacologists
37. Physical therapists
38. Physiologists
39. Prosthetists
40. Psychiatric social workers
41. Psychologists
    Clinical psychologists
    Counseling and guidance psychologists
42. Public Health Educators
43. Radiation therapy technicians
44. Recreational therapists
45. Rehabilitation therapists
46. Sanitary engineers
47. Sanitary inspectors
48. Speech therapists (speech pathologists)
49. Vocational counselors
50. X-ray technicians

* A representative but not inclusive tabulation of persons, other than physicians, other licensed practitioners of the healing arts, dentists, and nurses, who are engaged in investigation, treatment, and prevention of disease and disability, and in promotion of health by virtue of some special skill.

Menominee County

The Menominee County Study Committee of the CES Foundation submitted a report on the status of its health survey of the residents of Menominee County in November 1962. Among other recommendations, this report emphasized the desirability of obtaining a resident physician for the county.

Since submission of its report the committee has met twice and has made further recommendations in the areas of rehabilitation services to be made available if possible, and re-training of the woodworking employees of the mill, which is the only industry in the county and is known as Menominee Enterprises, Inc.

Several applications from physicians have been received and are being processed through the placement service of the State Medical Society, and currently are being considered by officials of Menominee Enterprises in cooperation with the Shawano County Medical Society.

The committee has recommended emphasis be placed on obtaining scholarship and loan aids for training younger citizens of Menominee County in the hope that the county may provide its own health personnel eventually.

Legislation

There will be an up-to-date report regarding legislation, virtually impossible at this time for the Commission on Public Policy.

There are, however, several matters which I wish to report as Chairman of the Council. In February the Council considered at length the matter of retirement of the aged, and because of pending legislation in the field approved a statement over the signature of President Hill which is incorporated here:

"Arbitrary retirement based solely on chronological age is widely regarded as undesirable in a free society which places a premium on individual accomplishment and dignity. This concept of retirement is clearly and positively stated in the eight-point program for the aged issued by the American Medical Association on February 19, 1963:

"'The AMA favors flexible policies which utilize the talents and abilities of employees as long as they are willing to work and are productive. Compulsory retirement and employment policies which reject workers solely because of age waste valuable human resources and contribute to physical and mental illness among the aged.'

"The State Medical Society wholeheartedly endorses this statement of policy and applies it to Bill 146, S. which, with some exceptions, would force the retirement of all employees of the state at age 65.

"Such a policy would deny these citizens the right which gave their life meaning prior to age 65—the right to work for the state. It ignores the fact of longer life and more alert living at older ages, to which modern medical care has contributed so much.

"It is unrealistic in light of the facts now available concerning the rising cost of supporting the older person in retirement, the recognized value of the older worker and the obvious contributions which he can make to society if his potential is properly used.

"The State of Wisconsin should instead provide leadership to industry and labor in this state by the adoption of truly flexible programs of retirement which recognize individual worth and initiative."

Another matter in the field of legislation is mental health. Our legislative counsel, Mr. Murphy, reports more than 25 bills in this general area and they are indeed very broad and of great importance. There has not been time, physically, to analyze these many bills and their complicated provisions. Speaking on behalf of the State Medical Society, Doctor Hill has suggested that so important a subject be one which is considered in interim study to make certain, as best interested parties can, that the health, well-being, and civil rights are properly protected.

Rather than incorporate President Hill's two statements to the Legislature on these important matters, they are attached to this report.

Wisconsin Work Week of Health

After adjournment of the 1962 session of the House of Delegates, it became incumbent upon the Council to review action taken at that time and in effect to inventory projects expected by the House to be carried out during the ensuing year.

We found the inventory a substantial one.

Study of administrative rules of state agencies as they relate to medicine and public health was authorized by the House.

Medical self-help received endorsement and instruction to promote.

Conference on medical aspects of caring for the aged had been authorized, as well as cooperation in an inventory of resources of the aged.

The study of the relationship of psychology to the practice of medicine was authorized, as was liaison with the nursing profession.

Other matters included endorsement and promotion of health fairs; the development of rural health conferences and institutes for hospital administrators and chiefs of staff, as well as a second conference on internship and residency.

Resolutions of the 1962 House were to be publicized, including those on hypnosis, seat belts, encouragement of physicians to provide professional advice in sports activities, and the more extensive health education of students preparing for careers in health.

These and many other projects led to the development of the Wisconsin Work Week of Health, the first of its kind in the country and one which proved eminently successful. The program was concerned with health appraisal of school aged children, including the roles of the school administrator, public health officials, the medical profession and others,

while another program was on the topic of the senior citizen; still another on public health; a highly successful program on Wisconsin industry and health with an in-plant tour including the nurse in occupational health.

Medical education and hospitals was moderated by Doctor Taylor, associate secretary of the Council on Medical Education and Hospitals, while an institute for hospital administrators and chiefs of medical staffs was sponsored by the Wisconsin Hospital Association and the State Medical Society.

There was an interprofessional day including such topics as the Medical Practice Act, the nursing law, and the rule-making powers of state administrative agencies. The program was combined with a conference of county medical society officers, and statements were contained as a matter of public education on health examinations of school children; guides for nursing homes; the homemaker services; the development of community health councils; the position of the Society in matters pertaining to occupational health, hypnosis, fluoridation, health departments, and similar topics. Health fairs were specifically promoted.

The House of Delegates should be aware of the many projects already assigned to the Council, to Council committees and to Standing Committees, and under Council direction coordinated planning has been developed to bring these matters to a successful conclusion in good time.

A Council committee is undertaking study of the possibility of developing medical-legal lecture series at the University of Wisconsin and at Marquette, with another broad study being devoted to the matter of area planning for hospitals and related health facilities. A medical-economic conference on a self-supporting basis has been recommended and approved by the Council, and will be held sometime in the fall of 1963.

Much House and Council activity is reflected in certain legislation, including modernization of the Basic Science Law and various public health matters such as health care of the aged in terminal illness, in which a pilot study associated with the deaths of persons over 65 is being conducted and findings are expected in the near future.

With the Council, the Commission on Public Relations and Communications has been considering a statement of policy to county medical societies concerning public appearances of physicians on television and radio.

Meetings have been held with representatives of nursing groups in a continuing attempt to improve liaison and understanding of mutual problems, and these meetings will be continued in the future.

The Society, through its Foundation, is cooperating with the University of Wisconsin in a research project on "Teaching Resources in Health Education." There is a mass of this material available, but with no indication of authoritativeness. The joint project is to enable teachers to have assurance, as much as possible, that material secured for use of their students is reputable and practical.

Pilot courses for obstetrical nurse training were approved and seem to meet a real need. The Society is cooperating with the Zor Shrine in the possibility of establishing a burn center facility in Wisconsin.

Health Fads and Fallacies

Probably one of the more ambitious programs of the past year has been this three-day conference, notice of which has been circulated to every member of the Society and many others. The first-day registration of over 250 brought individuals representing such interests as boards of health, children's service, women's clubs, senior citizens, hospitals, nursing homes, local friendship clubs, visiting nurse service, credit unions, private colleges, specialized schools of health education, social workers, home economists, homemakers clubs, dietetic association, and health councils.

Co-sponsoring agencies included the American Cancer Society, Wisconsin Division; Arthritis and Rheumatism Foundation; Dietetic Association; Pharmaceutical Association; American Dairy Association of Wisconsin; and Better Business Bureau of Milwaukee.

Many exhibits were offered in the areas of nutrition, quackery in gadgets, health fads and fallacies, and medical superstitions. The program attracted wide publicity throughout the state, and the purpose of the conference can best be expressed by the welcoming address of President Hill:

"Welcome to this first Wisconsin Conference on Health Fads and Fallacies.

"Health is a precious, indeed priceless gift. The high value with which people regard their personal well-being makes them targets for those who make a business of health frauds and semi-truths. Their activities constitute a public health problem which none of us can ignore.

"These health fads are costing the people of Wisconsin an estimated $20 million a year. Most people think quackery went out with the black derby and the traveling medicine man. However, it has never been more vicious nor more lucrative.

"From the physician's viewpoint, nothing is more discouraging than the health fraud that keeps sick people from getting proper medical care—in time—for ailments that could be cured.

"Furthermore, many publications carry feature articles on diet, obesity, low fat diets that have only slight basis on fact. Everyone becomes an authority on cholesterol. Titles like 'Calories Don't Count' sell like fiction—which they are for the most part. Every calorie counts, whether it is consumed as a liquid such as a cocktail, or as a solid such as butter, or a carbohydrate such as candy. There is simply no easy way to weight reduction. A recent book, *Poisons in Your Foods*, is full of errors in reporting and makes one wonder if books like these are published for any reason except to make money for the author and publisher.

"We hope that this Conference will be the opening gun for an all out war on food faddists, pseudo-scientific practitioners, mechanical gadgetry, mail order and house to house health frauds.

"State and national health authorities, law enforcement officials and voluntary health agency representatives will participate in the program. You will see special exhibits on quackery from the Food and Drug Administration, American Medical Association, American Cancer Society, American Arthritis and Rheumatism Foundation.

"We hope you will learn to evaluate what you read and see and alert the public to the dangers of quackery and also help set the stage for more effective law enforcement through cooperation between the public, health professions and local, state and federal enforcement bodies.

"In recognition of our obligation to bring this problem to the attention of the people of Wisconsin, the State Medical Society with support from many other agencies hopes to focus attention on this serious public health problem which attacks persons of all ages and in all walks of life.

"Thank you."

Conclusion

In concluding this report, the Council wishes particularly to commend President Hill and President-elect Egan. These two officials of the State Medical Society have most faithfully attended committee meetings and have participated in a wide number of events in behalf of Wisconsin medicine. Throughout the Work Week of Health and the Health Fads and Fallacies Conference, our President and President-elect were present, not only to greet but to meet people and confer with them in matters of public health interest.

The Council looks forward to another constructive year in 1963–64.

NECROLOGY REPORT

The Council reports with sorrow the deaths of the following physicians since the last Annual Meeting. Members of the Society are indicated in italic.

C. F. Ulrich, M.D., Kenosha
R. D. Bassuener, M.D., Milwaukee
W. G. Merrill, M.D., Ashland
F. H. Kelley, M.D., Merrill
M. F. Rogers, M.D., Milwaukee
W. F. Janc, M.D., Chippewa Falls
H. E. Froede, M.D., Silver Springs, Md.
F. B. Welch, M.D., Janesville
R. G. Raymond, M.D., Brownsville
C. W. Eberbach, M.D., Milwaukee
H. Aktekin, M.D., Superior
C. B. Strauch, M.D., Hazel Green
A. W. Davis, M.D., Madison
L. H. Guerin, M.D., Milwaukee
C. L. Rumph, M.D., Miami, Florida
A. H. Heidner, M.D., West Bend
S. O. Lund, M.D., Cumberland
A. J. Loughman, M.D., Oconomowoc
T. L. Tolan, M.D., Milwaukee
L. M. Morgan, M.D., Long Beach, Calif.
R. D. Taylor, M.D., Marshfield
J. M. Robbins, M.D., Milwaukee
W. H. McGuire, M.D., Janesville
E. A. Toussaint, M.D., Milwaukee
A. B. Gauger, M.D., Wadsworth, Kans.
W. P. Wheeler, M.D., Oshkosh
J. T. Morrison, M.D., Bethesda, Md.
A. F. Rheineck, M.D., Oconomowoc
A. Banach, M.D., Milwaukee
R. P. Sabin, M.D., Madison
G. A. Steele, M.D., Oshkosh
R. U. Cairns, M.D., River Falls
J. A. Cox, M.D., Milwaukee
S. B. Russell, M.D., Eau Claire
E. F. Andre, M.D., Kenosha
R. S. Irwin, M.D., Milwaukee
H. J. Zurheide, M.D., Elm Grove
C. F. Turney, M.D., Milwaukee
D. W. Curtin, M.D., Kimberly
M. C. Briggs, M.D., Milwaukee
J. J. Kazmierowski, M.D., Milwaukee
W. J. Meek, Ph.D., Honorary Member

LETTERS

Hon. Chester E. Dempsey, Chairman
Senate Committee on Public Welfare
State Capitol
Madison 2, Wisconsin

Re: Certain Bills Scheduled for Hearing April 17, 1963

Dear Senator Dempsey:

As president of the State Medical Society of Wisconsin, I am writing you with reference to certain of the bills which are scheduled for hearing before your committee on April 17, 1963. Neither the Division on Nervous and Mental Diseases nor the Public Policy Committee of the Society has considered these bills. I am, therefore, expressing a personal opinion as to them.

They are as follows:

370, S. This bill is concerned primarily with the conditional release of patients and the return of those who have escaped or have been on conditional release, parole or temporary discharge.

While I have not the slightest doubt that the bill is well intended and may well be needed, I inquire whether it may not be preferable for your committee or some other appropriate group to recommend a study of the desirability of updating all of Chapter 51 of the Wisconsin Statutes instead of taking the piecemeal approach. The Division on Nervous and Mental Diseases, the Public Policy Committee and the officers of the State Medical Society have all noted and commented upon the marked and rising interest in mental health on the part of the general public which is reflected in the large number of bills which are introduced in successive legislative sessions and in particular in the current one.

389, S. This bill appears to be purely technical and to contain statutory provisions which are necessary or desirable to qualify this state to receive certain federal funds for old-age assistance in the case of persons who are in a medical institution with a diagnosis of tuberculosis or a psychosis. I have no doubt that it might well be needed at this time and that it has been carefully considered by the State Department of Public Welfare which requested its introduction.

200, A. This bill would add rehabilitative facilities in Milwaukee County to the places to which an inebriate or drug addict may be committed. It is unquestionably an evidence of the advance in treatment of these cases, and, in my opinion, deserve legislative support.

While bill 167, S. has already been heard and is not part of your schedule for this week, I do wish to convey to you the divided reactions which its introduction has occasioned in various segments of medicine. Physicians recognize the good which such an interstate compact for mental health treatment might achieve, particularly where it was undesirable to return a mental patient to the state of his residence for a period of time. On the other hand the physicians, in common with others who have seen even the possibility of abuse in areas of commitment for alleged or actual mental illness, believe that no effort should be spared to assure that the bill has ample protection for the individual so that he can never be the victim of a system which works for many but which is unjust for him. Our attorneys suggested the possibility of a request for an Attorney General's opinion as to whether the bill was constitutional in form, and adequately protected the civil rights of the patient. I have reference to assuring, for example, that there is no impairment of the right to the writ of habeas corpus and similar safeguards which are so basic in our tradition and which medicine honors along with other citizens because it knows and values them so well.

If you or any of the members of your committee have any questions with reference to any of the above bills, or the Society could be of any service with reference to them, please feel free to call upon any of its officers or staff representatives at any time.

Sincerely yours,
/s/ N. A. Hill, President
State Medical Society of Wisconsin

NAH:es
cc: Hon. Peter P. Carr
Hon. Holger B. Rasmusen
Hon. Charles J. Schmidt
Hon. Martin J. Schreiber

* * *

Hon. Allen J. Busby, Chairman
Senate Judiciary Committee
State Capitol
Madison 2, Wisconsin

Re: Certain Bills scheduled for Hearing April 17, 1963

Dear Senator Busby:

As president of the State Medical Society of Wisconsin, I am writing you with reference to certain of the bills which are scheduled for hearing before your committee on April 17, 1963. The bills noted later have all been considered by the Division on Nervous and Mental Diseases of the Commission on State Departments of the State Medical Society. That division is comprised of psychiatrists, all of whom are in private practice, and a number of whom have been on the staffs of mental institutions or spend a portion of their time in such capacity, at present.

It occurred to me that it would be more useful to your committe to have a summary of the position of that division rather than individual appearances which take time and which must be difficult to keep in mind afterward. I express no opinion on the other bills scheduled for your hearings of this week because, for one reason or another, they have not been the subject of consideration by any committee of the Medical Society.

Following is a summary of the position of the division on the bills enumerated:

309, S. The division is opposed to this bill on the basis that it is preferable to have three adult residents who are close to the patient, and who are typically members of his family, apply for the examination of a person believed to be mentally ill, infirm or deficient. Physicians know how important it is in such cases to have full cooperation of the immediate family or others close to such patient. They doubt the wisdom of transferring this function to a psychiatrist or other physician even when the latter knows the condition of the patient.

310, S. The division thinks this bill makes good sense because the report of examining physicians under sec. 51.01 (4) can often be more conveniently filed in certificate rather than affidavit form.

311, S. The division approves this bill which applies to the report of examining physicians where an examination had been conducted for mental deficiency. In essence, this bill like 310, S., changes the form of the physician report from an affidavit to a certificate and is more convenient for the same reason as was expressed above as to bill 310, S.

313, S. The division supports this bill which gives county hospitals, in the discretion of the superintendent, the same right to treat patients temporarily detailed in them as now exists in a state hospital for the mentally ill.

314, S. This bill would make two amendments to existing statutes. The first is similar to 309, S. except that the former was concerned with those believed to be suffering from mental illness and 314, S. relates to inebriates and drug addicts. The Division on Nervous and Mental Diseases was divided on this bill and took no position for that reason. There was agreement that the legislation called for additional study. I think it could be said that the division expressed the same objection as to 309, S., namely that the responsibility for initiating commitment proceedings, unless the patient does so voluntarily, should rest primarily on his family or those with whom he lives.

While the division did not separately act on the point, I think that the provision on page 2, line 2 of the bill, permitting expansion from 3 to 10 days of the period for detention pending a hearing is very likely realistic.

315, S. The division supports this bill which will permit the discharge of a mental patient by the superintendent of any county hospital upon written recommendation of its medical director or visiting physician. The bill continues the required approval of the Department of Public Welfare. At present this provision is limited to Milwaukee County.

I am now going to offer a personal comment, Senator Busby, which I also heard from members of the various committees of the State Medical Society and others as they have considered the mental health and related bills summarized above, plus those heard last week and scheduled for this week in the Senate Committee on Public Welfare. That is the desirability of having a thorough-going study made between now and the 1965 legislative session as to the desirability of updating Chapter 51. This has not been done for some 15 years, and while mental health legislation in this state has been advanced and of generally high standard, and the legislature is entitled to great credit for its foresight and support in this important area, it may be time to take another look instead of substituting piecemeal legislation.

There is understandably continuing and even growing interest in the area of mental health. This is evidenced by the large number of bills which have been offered in the current session. I cannot help but think that it would be better to weigh the proposed changes against the overall pattern and philosophy of such an important law instead of hoping that no one change would cause unintentional dislocation of some other equally important and needed portion of the total legislative machinery for mental health care.

If you or any of the members of your committee have any questions with reference to any of the above bills, or the Society could be of any service with reference to them, please feel free to call upon any of its officers or staff representatives at any time.

Sincerely yours,
/s/ N. A. Hill, President
State Medical Society of Wisconsin

NAH:es
cc: Hon. Davis A. Donnelly
Hon. Ernest C. Keppler
Hon. Leland S. McParland
Hon. Earl D. Morton
Hon. John M. Potter

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—It recommended adoption of the report of the Council with emphasis on the following recommendations: (1) The Council should give the membership an explanation as to the method of its organization at the present time. (2) The Committee concurred with the feelings of the Council with respect to the sections on osteopathy, podiatry and matters of compulsory certification for licensure. (3) The Council should continue on an annual basis and if possible, with expansion, the two programs—Work Week of Health and Health Fads and Fallacies—which have done a great deal to form a better image of the Society as a whole and of the doctors who make up that Society. (4) Emphasis should be placed on obtaining scholarship and loan funds for training the younger citizens of Menominee County to assist that county in becoming more self-sufficient in future years. The Committee also noted the diligence and competence of Doctor Fox's many years of service and considered it a compliment to this Society to have him as chairman of the Council.

■ SUPPLEMENTARY REPORT OF THE COUNCIL —May 6, 1963

James C. Fox, M.D., La Crosse, Chairman

I take real pleasure in appearing before you to present a report of the Council which supplements that printed above. The Executive Committee of the Council met Saturday evening and Sunday morning, and the Council met Sunday afternoon and evening. It is interesting to note that every member of the Council was present, as were most of the officers.

The Section on Pathology asked the Council to present to the House a resolution affirming that the laboratory services rendered by a pathologist are medical services, and this resolution was amended by the Council to include radiology as well.

The Council suggests that after consideration of the resolution—copy of which is distributed with this report—it be referred to the Commission on Medical Care Plans for further implementation inasmuch as the practice of the pathologist and of the radiologist is already recognized as a medical service practice which should be incorporated in the appropriate insurance contract.

The Council transmits to the House the annual report of the Division on Safe Transportation of the Commission on State Departments which contains a recommendation relating to endorsement of the principle of implied consent for chemical tests for intoxication, and evaluation of specific legislative proposals which the Council suggests be referred to the Commission on Public Policy to consider whether they should have active support by the Society.

I should like to inform the House that James L. Weygandt, M.D., of Sheboygan Falls, and Walter F. Smejkal, M.D., Manitowoc, both appeared at the Council meeting yesterday to elaborate upon their report and the desirability of the medical profession taking action along the lines indicated. The fact that these physicians interrupted a pleasant Sunday to specially appear before the Council illustrates the interest of so many physicians throughout the state in affairs of the Society.

Among other matters reported to the Council yesterday was an opinion of the attorney general to the district attorney of Dunn County holding that treatment by a chiropractor is not medical treatment within the provisions of the Workmen's Compensation law, and that voluntary payment by a county which is self-insured would be an illegal expenditure of public funds.

This is an important opinion and is filed with each delegate for the information of his county society.

Also submitted with this report is the annual report of the Society's certified public accountants, Donald E. Gill & Company, summarizing financial and operating data on the State Medical Society and its related activities.

Another resolution is introduced by the Council with this supplementary report. It relates to External Cardiac Massage and was presented by Dane County delegates.

I should now like to read an important proposal submitted to the Council by the Commission on Medical Care Plans, which is forwarded to the House with the Council's wholehearted endorsement:

Conference on the Extension of Voluntary Health Insurance

Consistent with the avowed purposes of Wisconsin Physicians Service, the Commission on Medical Care Plans of the State Medical Society of Wisconsin, with concurrence of the Council, respectfully recommends for consideration by its House of Delegates the sponsorship of a Fall, 1963 Conference on the Extension of Voluntary Insurance.

The name of the proposed conference suggests both its theme and its objective . . . that of bringing together *all* forces interested in expanding the breadth and scope of voluntary health insurance. This would include but not be limited to commercial insurance carriers, (life, casualty and health) Blue Cross, the Wisconsin Dental Service Corporation, the two Blue Shield Plans of Wisconsin, the state pharmacists, health insurance producers, organizations whose purposes include the preservation of the private enterprise health insurance system, the Wisconsin Insurance Department and other state governmental agencies having an interest in the subject, the Wisconsin Hospital Association and all other similar associations or organizations representing or related to segments of medical care.

Held in the offices of the State Medical Society of Wisconsin the principal purpose of the conference would explore to the greatest extent practicable, opportunities for research and experimentation into added fields of health care. This would include, for example, discussions or proposals relating to health insurance benefits designed for the chronically, physically ill and those in need of short-term treatment of mental ailments.

Speakers on these and other problems pertinent to the prefinancing of health care would be selected on the basis of their known specialized interest in seeking solutions through the voluntary insurance mechanism. Specific reference to the nature and extent of the problem and the feasible means of its correction would be encouraged.

Following the conference, copies of the papers or presentations would be made available promptly to the interested press and thereafter to all participants as well as to others requesting them.

It is suggested that the conference commence in the early afternoon, that an evening session be held, and that the conference be concluded at noon the following day. It is further suggested that attendees be guests of Wisconsin Physicians Service at dinner the first day of the conference following a tour of the Society's facilities. Assuming the attendance of 150 participants, it is estimated that the total cost to Wisconsin Physicians Service, including the reimbursement of speakers' travel expenses and honoraria, if any, will not exceed $3,000.

The Commission on Medical Care Plans sincerely believes that there is not only an urgent need for this type of conference but that its sponsorship by the State Medical Society of Wisconsin is completely compatible with its responsibility to provide forward-thinking leadership in the advancement of health care prepayment programs.

Finally, we regard the home of Wisconsin medicine as the appropriate setting for an interchange of ideas by all concerned with continuous progress in the health care of all of its citizens.

Finally, the Council urges that the House release the following statement on implementation of the Kerr–Mills law in Wisconsin:

"The Wisconsin Pharmaceutical Association, the Wisconsin State Dental Society, the Wisconsin Hospital Association, and the State Medical Society of Wisconsin have collaborated in the preparation of bills (408, S. and 647, A.) to implement Kerr–Mills law in Wisconsin. These are scheduled for public hearing before the Senate and Assembly Public Welfare committees on May 15.

"The Kerr–Mills law provides special assistance to those senior citizens whose financial circumstances are such that they cannot afford all or a part of the cost of adequate health care in time of need.

"The responsibilities of Wisconsin legislators and the Executive Department in this nonpartisan health legislation should be of deep concern to the senior citizens of Wisconsin.

"This federal law should be promptly and effectively implemented. Bipartisan support is needed and deserved to pass this type of financial assistance to our senior citizens. As important as the construction of highways and conservation of our natural resources are to the people of Wisconsin, the increasing numbers of aged have added another problem of equal importance.

"These bills permit the Blue plans of Wisconsin and licensed insurance companies to contract through the state to administer hospital, nursing home, dental, drug, nursing and medical benefits for those of the senior citizens who need that type of special assistance.

"This is not general public assistance and it is for that reason that administration would be through the voluntary insurance system.

"Thirty-two states and four territories have implemented Kerr–Mills. Why not Wisconsin?

"Each county medical society in Wisconsin should utilize newspapers, radio and television to the extent possible to promote passage of this enabling legislation and arrange dissemination of this statement, in whole or in part, through the advertising facilities of the media in their communities.

"Senior citizens, whether in need of such financial assistance or not, are used to make their voices heard on this important issue.

"Wisconsin hospitals, dedicated to public service through their administrators and their board of trustees or advisory councils, have a duty to voice their concern to the people of their communities."

Resolution No. 9
Introduced by: Council

WHEREAS, The practices of Pathology and Radiology have been declared repeatedly to be the practice of medicine by the American Medical Association, State Medical Society of Wisconsin, College of American Pathologists, American College of Radiology, by the courts and by the statutes of the State of Wisconsin; and

WHEREAS, The Wisconsin Physicians Service is a health care insurance plan operated by the Wisconsin Medical Society and insures patients for both hospital and medical services; and

WHEREAS, Clinical laboratory and radiologic services are now being paid for by WPS as hospital services; therefore be it

Resolved, That the WPS plan of the State Medical Society conforms to recognition of pathology and radiology as the practice of medicine, and be it further

Resolved, That the WPS of the State Medical Society reaffirm that laboratory services rendered by a pathologist and radiologic services in and outside the hospital be insured under the medical service rather than the hospital service contract or rider.

Report of the DIVISION ON SAFE TRANSPORTATION

Implied Consent For Chemical Tests for Intoxication

Annually over 900 persons are killed in Wisconsin traffic accidents. Numerous studies have revealed that over half of the drivers responsible for fatal accidents had significant quantities of alcohol in their systems at the time of the accidents. A considerably higher number of people are injured in traffic accidents each year, and it can be assumed that alcohol is a significant contributing factor. In view of these statistics, the Division has devoted a major portion of its activity in the past year to a study of chemical tests for intoxication and the subject of "implied consent" for such tests.

As a result of this study, the Division has concluded that the interest of medicine in the prevention as well as treatment of accidental injuries, and the specific question of a medical procedure used in enforcement activities, make it desirable for the State Medical Society to take official action in this matter.

IT IS RECOMMENDED THAT THE STATE MEDICAL SOCIETY OF WISCONSIN ENDORSE THE PRINCIPLE OF IMPLIED CONSENT FOR CHEMICAL TESTS FOR INTOXICATION AND THAT SPECIFIC LEGISLATIVE PROPOSALS BE EVALUATED AND CONSIDERED FOR ACTIVE SUPPORT BY THE SOCIETY.

It is felt that appropriate legislation will provide the courts with scientific evidence, to be utilized with other valid evidence, in determination of the guilt or innocence of a person accused of operating a motor vehicle while intoxicated, and the end result will be more adequate enforcement and consequently a decrease in the number of injuries and deaths due to traffic accidents.

Transporting the Ill and Injured

It is also the concern of the medical profession that the ill and injured receive proper first aid and safe transportation to a location where medical treatment is rendered. Consequently, a major project of the Division has been the development of a guide and a model ordinance to assist in the organization and improvement of these services at the local level. This guide, which will include recommendations on qualifications of personnel, equipment and maintenance of vehicles, and conduct of emergency vehicles in traffic, is nearing completion and will be submitted in the near future for consideration as an official Society publication.

Crash Injury Research

In June the Society will conclude participation in a two year study of automobile accidents involving death or injury. The study, being carried out in cooperation with Automobile Crash Injury Research of Cornell University and other Wisconsin organizations, has resulted in the collection of much valuable data. Cornell University has requested, and the Division has recommended, that the study be continued for another year, but with coding of the report forms to assure no disclosure of identity of the occupants of the cars and to eliminate a question which required the physician to express judgment rather than fact as to the cause of the accident.

Results of the study, utilizing data from Wisconsin and other participating states, are used by automotive designers to eliminate those features of present automobile construction which contribute to injury and death in case of accident.

Other Activities

During the past 12 months, the Division has attended a part of the Mid-Winter Safety Conference of the Wisconsin Council of Safety, met with Paul Joliet, M.D., chief of the Division of Accident Prevention of the U. S. Public Health Service, recommended Society co-sponsorship of a promotional effort of the State Motor Vehicle Department concerning the value of auto seat belts, and discussed features of possible legislative proposals. It has also noted the efforts of H. Kent Tenney, M.D., director of the Society's "March of Medicine" radio program, to promote traffic safety through periodic programs on the subject.

Conclusion

The Division feels its efforts during the past 12 months have been intensive in areas which particularly concern medicine and the practicing physician. With the satisfactory conclusion of these projects, it will be able to turn its attention to new areas of medical interest within the field of safe transportation during the coming year.

DIVISION ON SAFE TRANSPORTATION

Richard B. Windsor, M.D., Sheboygan
J. L. Weygandt, M.D., Sheboygan Falls
Milton Trautmann, M.D., Prairie du Sac
W. F. Smejkal, M.D., Manitowoc
E. M. Randall, M.D., Boscobel
Frederick Bunkfeldt, Jr., M.D., Milwaukee
George Anderson, M.D., Stevens Point
R. C. Wixson, M.D., Madison

LETTERS

Mr. C. M. Meisner
District Attorney
Dunn County
Menomonie, Wisconsin

Dear Mr. Meisner:

You have requested my opinion as to whether or not payments made by Dunn County to chiropractors for treatment of injured employees would be an illegal expenditure of public funds. You point out in your request that Dunn County is a "self-insurer" under the Workmen's Compensation Act. You also point out that medical treatment, as required by sec. 102.42 (1), Wis. Stats., is made available to all injured employees, but that occasionally an injured employee requests chiropractic treatment in lieu of medical treatment. It is your opinion that chiropractic treatment is not "medical treatment" within the meaning of sec. 102.42 (1) Wis. Stats.; that any payment by the County for chiropractic treatment given an injured employee, therefore, would be a voluntary payment by the County not authorized by law and, accordingly, that such payment would be an illegal expenditure of public funds. In support of your opinion, you cite *Corsten v. Industrial Comm.* (1932), 207 Wis. 147, 240 N. W. 834.

It is my opinion that you are correct that chiropractic treatment is not "medical treatment" within the meaning of sec. 102.42 (1) Wis. Stats. Accordingly, payments by the County for chiropractic treatment given an injured employee in lieu of medical treatment are not authorized or required by sec. 102.42 (1), Wis. Stats., and such payments by the County would, therefore, be an illegal expenditure of public funds.

Corsten v. Industrial Comm., supra, is controlling. In the *Corsten* case a municipal employee included in his claim for workmen's compensation an item covering a charge by a chiropractor for treatment of injuries he had sustained while in the course of his duties as a fireman for the City of Green Bay. The Industrial Commission disallowed the claim for chiropractic treatment. The Circuit Court entered judgment vacating the Commission's order and directed that the item be allowed. On appeal, the Supreme Court reversed the Circuit Court judgment with directions to confirm the order of the Industrial Commission disallowing the claim for chiropractic treatment. The statute at that time provided, in part, that the expense of treatment recoverable was "* * * medical, surgical, and hospital treatment * * *." Section 102.09, Wis. Stats., 1927. In holding that chiropractic treatment is not "medical treatment" within the meaning of Chapter 102, the Supreme Court stated, in part, as follows at pages 148–150:

> "The learned circuit judge based his reversal upon the idea that chiropractors give medical treatment as that term is defined in ch. 147 of the Statutes, which is headed 'Treating the Sick' and governs the practice of medicine and surgery. While it is true that according to that chapter chiropractors do treat the sick and that their treatment is 'medical treatment,' it does not necessarily follow from this that it is such medical treatment as the workmen's compensation act contemplates.

State Medical Society of Wisconsin
Madison, Wisconsin

Financial and Operating Data on the Society and its Related Activities
December 31, 1962 and Year Ended That Date

	S.M.S. General Fund	W.M.J.	W.P.S.	Medicare	S.M.S. Realty Corp.	Pension Plan	Foundation
Financial Condition - December 31, 1962							
ASSETS							
Current	$154 394 24	$19 357 42	$4 628 520 22	$104 334 67	$ 55 942 86	$147 182 68	$ 46 434 95
Long-term and Fixed (Net)	24 254 48	1 018 09	813 444 10		770 915 44		268 967 13
Other	10 232 75	1 353 47	29 799 08		4 205 33	41 67	679 87
TOTAL	$188 881 47	$21 728 98	$5 471 763 40	$104 334 67	$831 063 63	$147 224 35	$316 081 95
LIABILITIES, RESERVES AND CAPITAL							
Current	$ 35 931 25	$ 5 666 17	$1 665 110 55	$ 4 334 67	$ 53 329 33	$ 262 01	$ 16 318 27
Fixed		16 062 81		100 000 00	567 500 00		55 000 00
Deferred Income	22 557 50		1 326 836 19				
TOTAL LIABILITIES	$ 58 488 75	$21 728 98	$2 991 946 74	$104 334 67	$620 829 33	$ 262 01	$ 71 318 27
Reserves	42 170 10		2 479 816 66		59 753 90		
Special Capital						146 962 34	244 763 68
Current Surplus and Donated Capital	88 222 62				150 480 40		
TOTAL	$188 881 47	$21 728 98	$5 471 763 40	$104 334 67	$831 063 63	$147 224 35	$316 081 95
Income and Expenditures - Year Ended December 31, 1962							
INCOME							
Dues	$300 951 75	$	$	$	$	$	$
Premiums			11 040 976 38				
Special Assessment	82 170 10						
Other	30 864 97	52 158 86	149 970 52	28 671 40	143 927 01	4 887 47	57 191 59
TOTAL	$413 986 82	$52 158 86	$11 190 946 90	$ 28 671 40	$143 927 01	$ 4 887 47	$ 57 191 59
EXPENDITURES							
Benefits	$	$	$9 468 532 39	$	$	$	$
Administration	322 280 14	53 650 44	1 296 283 61	28 671 40	129 536 06	1 498 15	28 295 05
Survey Expense	40 000 00						
TOTAL	$362 280 14	$53 650 44	$10 764 816 00	$ 28 671 40	$129 536 06	$ 1 498 15	$ 28 295 05
Excess-Income Over Expenditures	$ 51 706 68	($ 1 491 58)	$ 426 130 90	$	$ 14 390 95	$ 3 389 32	$ 28 896 54
Deduct: Transfers to Special Reserves	42 170 10				9 004 67		
Total	$ 9 536 58	($ 1 491 58)	$ 426 130 90	$	$ 5 386 28	$ 3 389 32	$ 28 896 54
Add: Transfer from Security Valuation Reserve			36 933 93				
BALANCE	$ 9 536 58	($ 1 491 58)	$ 463 064 83	$	$ 5 386 28	$ 3 389 32	$ 28 896 54

( ) Denotes Red Figure

The legislature might give such meaning under the act to the term 'medical treatment' as it saw fit, whether it corresponded with the definitions of ch. 147 or not. Doubtless we should hold that under the act the term has the same meaning as in ch. 147 unless the act indicates clearly that it uses the term with a different meaning. But we are of opinion that under the act the only medical treatment contemplated is medical treatment administered by a physician; and we are also of opinion that a chiropractor is not a physician as that term is used in the act and in ch. 147.

"* * *

"* * * It is held in *Isaacson v. Wisconsin Casualty Asso.* 187 Wis. 25, 203 N. W. 918, that a chiropractor is not a 'legally qualified physician' under the terms of an accident insurance policy, even though he does treat the sick in a restricted way. The conclusion seems to be based upon the fact that under the statute as it then stood chiropractors might 'practice their profession' without procuring a license and the term 'legally qualified physician' in the policy meant a 'licensed physician,' but it seems plain that it might as and perhaps more reasonably have been held that a chiropractor was not a physician at all. The definition of physician first given in Bouvier's Law Dictionary (2 Rawle's 3d ed. 2586) is: 'A person who has received the degree of doctor of medicine.' One of the definitions in Webster's Dictionary is 'a doctor of medicine.' In line with these definitions and ch. 147, we are of opinion that the word 'physician' as used in the compensation act does not include a chiropractor."

Insofar as it is material here, the Workmen's Compensation Act has not been amended in any way to warrant the conclusion that the holding in the *Corsten* case has been changed. On the contrary, the relevant sections of Chapter 102, as well as the legislative history since the decision in the *Corsten* case are conclusive that chiropractic treatment is not medical treatment within the meaning of the Compensation Act. Section 102.42 (1), Wis. Stats., provides, in part, as follows:

"102.42 Incidental compensation. (1) The employer shall supply such medical, surgical and hospital treatment, medicines, medical and surgical supplies, * * *."

While there have been numerous attempts since 1932 to have Chapter 102 amended to specifically authorize and require payment for chiropractic treatment under the Workmen's Compensation Act, all such efforts have met with failure. The most recent efforts in this direction occurred at the last session of the Legislature, and a bill was introduced in the Assembly (Bill No. 340, A) and a bill was introduced in the Senate (Bill No. 249, S) to permit payment for chiropractic treatment under the Workmen's Compensation Act. Bill No. 340, A was defeated and Bill No. 249, S was indefinitely postponed (Bulletin of the Proceedings of the Wisconsin Legislature, 1961—Senate and Assembly Volumes; 1961 Index to the Legislative Journals). The construction given to the statute by the Supreme Court in the *Corsten* case became a part of the statute and is controlling since the Legislature did not subsequently amend the statute so as to affect a change. *Hahn v. Walworth County* (1961), 14 Wis. (2d) 147, 154, 109 N. W. (2d) 653. This is particularly true since the Legislature has been expressly requested several times to amend the statute in a manner to change the result in the *Corsten* case, but has declined to do so. In this connection, the Industrial Commission of Wisconsin has written to me with respect to your question, and in their letter of April 18, 1962, they state as follows, in part:

"The Industrial Commission has no recollection of, or written evidence to support, any action by the commission since its inception which recognizes chiropractic treatment as resulting in the equivalent of 'medical treatment' by 'physicians' as prescribed by the provisions of the W. C. Law. Many efforts have been made by the Chiropractic Association through legislation which might place them on a par with physicians for the rendering of medical care and treatment to compensation claimants. All of these efforts to date have been unsuccessful * * *."

Of course, the County may not pay out public funds gratuitously, and it would be unlawful for the County to pay for chiropractic treatment rendered to an injured County employee since such payment is not authorized or required by law. *Quayle v. Bayfield County* (1902), 114 Wis. 108, 115–116, 89 N.W. 892.

You are therefore advised that County payments for chiropractic treatment under the Wisconsin Workmen's Compensation Act are not authorized, and a voluntary payment for such treatment would be an unlawful expenditure of public funds.

Very truly yours,

/s/ John W. Reynolds
Attorney General

JHB:msa

To the Council of the State
Medical Society of Wisconsin

Gentlemen:

Attached is a tabulation showing Financial Condition and Income and Expenditures of the State Medical Society of Wisconsin and its related activities. Financial condition is shown as of December 31, 1962. Income and expenditures are those for the year ended December 31, 1962.

The information shown, with the exception of that for the Foundation, is taken from our audit reports for the year ended December 31, 1962. The "General Fund" includes transactions related to the Special Assessment. Information on the Foundation is consolidated with that of the Student Loan Fund and was supplied to us by the Society's Accounting Department. We have audited the records of the Foundation and the Student Loan Fund at June 30, 1962, the end of the most recent fiscal year.

Certain footnotes and contingent liabilities which are a part of statements in our audit reports are incorporated in this report by reference. As you know, detailed information on each of these activities is presented to, and reviewed by appropriate committees or boards of the Society.

In the attached tabulation inter-activity receivables and payables included in assets and liabilities, and itemized in our separate audit reports, are not eliminated. Also, employer and employee contributions to the Pension Plan, which totaled in 1962 $26,666.53, are treated not as income but as additions to principal of the Plan.

This information is supplied to you in accordance with a recommendation of the Reference Committee on Reports of Officers to the 1960 session of the House of Delegates, duly adopted.

Respectfully submitted,

/s/ Donald E. Gill & Company
Certified Public Accountants

RESOLUTION NO. 8

Introduced by: Council

WHEREAS, External Cardiac Massage is an important adjunct to emergent care of some patients; and

WHEREAS, Proper instruction of rescue squads, ambulance squads and others dealing with emergency care is necessary and desirable; therefore be it

Resolved, That each county medical society make available a source of competent instruction from among its own members, in cooperation with the Wisconsin Heart Association or from other cooperating organizations, to any authorized emergency care personnel who may desire its assistance in obtaining external cardiac massage rudiments and instruction.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—It recommended release of the statement on implementation of the Kerr–Mills law in Wisconsin with endorsement of the House of Delegates, deleting the last paragraph and the third-last paragraph. The Reference Committee strongly urged that each county medical society utilize newspapers, radio, and television to the extent possible to promote passage of this enabling legislation and arrange dissemination of this statement, in whole or in part, through the advertising facilities of the media in their communities. It further stated that Wisconsin hospitals, dedicated to public service through their administrators and their boards of trustees or advisory councils, have a duty to voice their concern to the people of their communities.

HOUSE OF DELEGATES ACTION—Accepted the recommendations of the Reference Committee.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—It recommended adoption of the proposal regarding a Conference on the Extension of Voluntary Health Insurance by the Commission on Medical Care Plans, but it emphasized that reference should be included to labor and management as "other interested parties."

HOUSE OF DELEGATES ACTION—Adopted the report as recommended by the Reference Committee.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—It recommended acceptance of Resolution No. 9, with the following changes in the last 'resolved': "Resolved, That the WPS of the State Medical Society reaffirm that services rendered by a pathologist or radiologist in and outside the hospital be insured under the medical service rather than the hospital service contract or rider." It further recommended that this resolution be referred to the Commission on Medical Care Plans for study and implementation.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 9 as amended and recommended by the Reference Committee.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—It recommended that the State Medical Society of Wisconsin endorse the principle of implied consent for chemical tests for intoxication, and that specific legislative proposals be evaluated and considered by the Commission on Public Policy for active support by the Society. The Committee stated that this is one way of curbing the mortality rate in this state due to traffic accidents. The Committee also expressed its anticipation of a division report in the future upon completion of studies which include safe transportation of the ill and injured, and the crash injury research study. It commended the Division on Safe Transportation of the Commission on State Departments and expressed its appreciation for the continuance of present high caliber efforts in other new areas in the future. It recommended adoption of the report of the Division on Safe Transportation.

HOUSE OF DELEGATES ACTION—Adopted the report of the Division on Safe Transportation of the Commission on State Departments as recommended by the Reference Committee.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—It recommended adoption of Resolution 8 with the following amendment: Insertion of additional paragraph between the second and the last paragraph of the original resolution, so that it would read . . . "Resolved, That the State Medical Society of Wisconsin urge all its member physicians to become familiar with the technique of external cardiac resuscitation as well as the proper medical care of such patients after they are 'delivered' to hospitals by non-medical personnel administering external cardiac resuscitation; and be it further" . . .

HOUSE OF DELEGATES ACTION—Adopted Resolution 8 as amended and recommended by the Reference Committee.

■ REPORT OF TREASURER—1962–1963

F. L. Weston, M.D., Madison

In accordance with Section 3, Chapter 5 of the Bylaws of our Society, I submit to you my annual report.

As in previous years I am reporting to you here only on those funds which are the direct responsibility of the Treasurer, designated as the Society's "General Fund". Information on financial condition and income and expenditures of related activities of the Society is submittted to you separately in accordance with a recommendation made to you in 1960 by the Reference Committee on Reports of Officers, which you adopted.

The following Exhibits and Schedules make up this report:

Exhibit A—Financial Statement at December 31, 1962

Schedule A-1—Reconciliation of Net Worth at December 31, 1962

Exhibit B—Statement of Income and Expense—General Fund—Year Ended December 31, 1962

Exhibit C—Statement of Income and Expense—Special Assessment—Year Ended December 31, 1962

The records of the State Medical Society of Wisconsin have been audited for the year 1962 by Donald E. Gill & Company, Certified Public Accountants. A representative of this firm is present and available for consultation during the course of this Annual Meeting.

Exhibit A

State Medical Society of Wisconsin
General Fund
Madison, Wisconsin

FINANCIAL STATEMENT
December 31, 1962

ASSETS		
Cash	$134,511.34	
Accounts Receivable	1,425.25	
Due from Society Divisions—Current	10,970.64	
Due from Related Organizations—Current	7,062.01	
Guaranty Deposit	425.00	
Working Capital Advance—Wisconsin Medical Journal	16,062.81	
Furniture and Equipment—Cost Less Depreciation	8,191.67	
Prepaid Expenses and Deferred Charges	10,232.75	
TOTAL ASSETS		$188,881.47
LIABILITIES, RESERVES AND NET WORTH		
Liabilities		
Accounts Payable	$ 13,412.02	
Due Officers and Employees	796.43	
Dues—Suspense	1,972.80	
Accrued Payroll Taxes	19,750.00	
Prepaid Membership Dues	8,340.00	
Other Prepaid Income	14,217.50	
Total Liabilities		$ 58,488.75
Reserves		
Special Assessment		42,170.10
Net Worth		
Surplus—General Fund	$ 66,755.81	
Net Worth of Wisconsin Medical Journal	16,062.81	
Surplus Reserved for Section on Medical History	579.00	
Surplus Reserved for Legislative Expenditures	1,825.00	
Surplus Reserved for Open Panel	3,000.00	
Total Net Worth		88,222.62
TOTAL LIABILITIES, RESERVES AND NET WORTH		$188,881.47

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin.

Gifts may take a number of forms such as cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary of their wills.

In any event, all contributions to the Foundation are deductible for income tax purposes.

Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.

Schedule A-1

State Medical Society of Wisconsin
General Fund
Madison, Wisconsin

RECONCILIATION OF NET WORTH
Year Ended December 31, 1962

	Section on Medical History	Wisconsin Medical Journal	CARRY-OVER		Unappropriated Society Surplus	Total
			Open Panel	Legislative Expenditures		
Balance—January 1, 1962	$ 962.04	$18,354.39	$	$	$61,661.19	$80,977.62
Additions						
Excess—Income over Expenses	(383.04)	(2,291.58)	3,000.00	1,825.00	5,094.62	7,245.00
Balance—December 31, 1962	$ 579.00	$16,062.81	$ 3,000.00	$ 1,825.00	$66,755.81	$88,222.62

( ) Denotes Red Figure

Exhibit B

State Medical Society of Wisconsin
General Fund
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1962

INCOME		
Membership Dues	$300,351.75	
Dues—Section on Medical History	600.00	
Annual Meeting	27,271.01	
Administrative Services	1,800.00	
Miscellaneous Income	1,648.96	
Gain on Disposal of Fixed Assets	145.00	
TOTAL INCOME		$331,816.72
EXPENSES		
Auditing and Accounting Consultation Services	$ 5,257.11	
Conference Expense	25,194.32	
Depreciation	2,836.01	
Grants and Appropriations	24,528.04	
Legal Services	12,419.50	
Legislative Retainer	8,900.00	
Office Supplies	2,214.04	
Outside Services	8,470.39	
Payroll	129,070.38	
Payroll Taxes and Employee Benefits	12,400.58	
Postage and Express	7,503.78	
Printing and Forms	14,680.90	
Promotion	16,753.23	
Rent—Central Office	24,113.75	
Rent—Other	6,974.85	
Telephone and Telegraph	3,625.70	
Travel Expense—Staff	10,447.64	
Other Expenses	17,411.07	
Total	$332,801.29	
Less: Portions of Above Expenses Charged Out for Services Rendered to Others	10,521.15	
TOTAL EXPENSES		322,280.14
EXCESS—INCOME OVER EXPENSES (TO NET WORTH)		$ 9,536.58

Exhibit C

State Medical Society of Wisconsin
Special Assessment
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1962

Special Assessment Income	$ 82,170.10
Less: Expense	40,000.00
Reserve for Special Assessment (To Reserves)	$ 42,170.10

Charges by the Medical Society of Milwaukee County or the State Medical Society for their added expense are not reflected here, nor any expenses incurred after December 31, 1962.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—The Committee examined the report of Donald E. Gill and Company with interest and satisfaction. Following this, it examined the report of the treasurer, and as usual, found it to be clear and accurate. It recommended adoption of the Treasurer's report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Treasurer as recommended by the Reference Committee.

■ REPORT OF SECRETARY—1962–1963

Mr. C. H. Crownhart, Madison

Since May of 1962 the State Medical Society has engaged in an energetic year of new ventures in implementing actions of the House. Most of them have been reported in one way or another through the media of the Journal and various bulletins. But I feel a comprehensive report is indicated at this time as the delegates look forward to another year.

For some years the Society has sponsored one day or half-day institutes in other than scientific medicine, and has released statements of policy to the news media which have received varying degrees of publicity. While all of these programs have real value, still it seemed to the Councilors and Officers that the Society was not getting the most for its investment, including the time of physicians and staff.

The Wisconsin Work Week of Health

Consequently, the Wisconsin Work Week of Health came into being—a novel effort to put accent on health through a series of presentations and discussions. The program format was developed in such manner as to relate statements of principles on various topics, and these statements "faced" an appropriate page in the week's program. Approximately 13,000 programs were distributed to individuals prominent in state and local civic activities. More than 1,000 persons attended the week, and all in all it was felt that the Society accomplished more, effectively and economically, than in the pattern of other years.

The Wisconsin Work Week of Health will be held again during the week of February 23, 1964, and planned in such manner that it will again conclude with the Annual Conference of Officers of County Medical Societies and with the annual meeting of the Council.

Medicine is a Totality

Delegates will note that a written legislative report is not being submittted at this time. However, we expect to give an up-to-date report at the time the House meets. With some exceptions, there has

not been final action on bills of concern to the State Medical Society, but the tempo of legislative activity is picking up and there certainly will be developments to report by the time of the Milwaukee meeting.

However, I think the House will wish to gear its thinking to some changes in the method of presenting medicine's views on various legislative matters. Medicine is a total art and science, although the particular skill and interest of individual physicians may be directed to a specialized area. There is a tendency these days for physicians to be concerned primarily with such legislation as has some impact upon their specialty or special interest. In an effort to bring legislative matters back to the total of medicine, two conferences of section delegates, alternates and officers, and officers of specialty societies and the Academy of General Practice, have been held in Madison. I think that these, conducted over a period of time, will do much to reemphasize medicine's total responsibility in matters of public health.

It is not intended that the meetings be concerned exclusively with legislation, and in legislative "off years" in particular, there can be emphasis on various studies being conducted by the Society and by state boards and commissions, as well as developments on the national scene. It is hoped that through this means of communication the specialty groups will be better informed in all these areas of concern.

Planning Ahead

The west wing addition to the building provides a meeting area which can accommodate approximately 150 persons at tables, and more than 200 if set in auditorium style. This facility has been much needed by the Society and will permit the development of programs of many varieties to bring the public to medicine. The Work Week of Health was illustrative of what can be accomplished. In the year 1963–64 we look forward to having five or six scientific programs, worked out in conjunction with the UW School of Medicine. While planning is not as yet final, dates have been selected for two such meetings this fall, and three—possibly four—next year, with the morning devoted to "wet clinics" at medical school facilities, and lunch and a didactic program at the Society in the afternoon.

At the time of writing this report a number of the staff are assembling the exhibits for the Conference on Health Fads and Fallacies. These displays will be open to public viewing, and the program itself will be open to the public. We have no measure to determine what interest will be developed out of this conference, but it seems to be of considerable public interest and may be an affair which should be repeated, not as an annual event, but at least biennially. Perhaps an evaluation of this conference can be provided at the time of the Annual Meeting.

The meeting facility as a matter of policy will be limited in use to affairs having health interest. Thus far the "Presidents' Room," as the area is known, has been used for quite a few medical meetings; a meeting of the wives of attorneys and physicians practicing in the Madison area; and a meeting of about 65 girls who came from Eau Claire to learn of health career training available from the University. A poison control seminar brought a large number of people to the building from various areas of the state.

One of the more interesting affairs held at headquarters was a tour group of French physicians and their wives totaling around 70 in number. These physicians belong to an academy of rural physicians and their interest in the Madison vicinity was in group practice in smaller communities, rural hospitals, and the use of closed circuit television for training purposes. Arrangements were made to take a portion of the group to Columbus and another portion to Stoughton, visiting offices of physicians enroute. They met at the Society, were greeted by President Hill, and returned here after their tour of the area, while the wives were being entertained in the homes of physicians. This event, again, is reported here largely as illustrative of the diverse ways in which the meeting facilities are serving a good purpose in behalf of all the members.

We are hopeful that the specialty groups which can be accommodated in the Presidents' Room will hold at least one of their meetings there the next two years, and that perhaps it can become traditional to hold one meeting a year at the Society to emphasize that these groups are indeed a part of the total of medicine.

I am gratified that the Council is recommending that there be a regular fall session of the House of Delegates in the foreseeable future. This will have some distinct advantages for delegates, committees, and staff, particularly in spreading the work load of reporting, and providing more time for consideration of important matters. New hotel facilities in Madison are developing at such a rate that it should be possible within the next several years to hold the Annual Meeting in the capital city.

The CES Foundation

I would like to talk with you about this for a moment, and while these remarks may to some extent be included in the Foundation's report separately submitted, still I feel that from the viewpoint of general management I should like to emphasize several things that will fortify the Foundation in the future.

The time is here, but the money isn't, to create the position of full-time director. Until that day comes, direction of Foundation activities has been shared by quite a few people in the staff, and thus there is the tendency to let matters "go" in the press of other work.

Yet the Foundation has been remarkable in its achievements to date. Virtually all scientific activities of a postgraduate nature, and other than the Annual Meeting affairs and the Medical Journal, are now channeled through mechanisms of the Foundation. The Council has authorized appropriations from the dues structure to aid in these projects, and the Foundation offers the device under which financial aid from other organizations can be accepted. This is beginning to build a head of steam which promises well for the future; but the fire must be stoked constantly.

Acquisition to date of valuable collections and memorabilia shows the long-range success of this program. Culminating some four years of effort, the seven original Bohrod oil paintings commissioned by Eli Lilly and Company are now the gift of its Foundation to our Foundation. These paintings will be available for display throughout the State of Wisconsin, so long as there can be assurance that they will be carefully protected during any such circumstance. We have insured these paintings for $20,000.

A year ago the American College of Surgeons gave us five dioramas which were on display for a time in Madison while they were being cleaned up and repainted. This was a very expensive project of the ACS some 30 years ago, and the dioramas constitute an exceptionally fine type of presentation of outstanding events in the history of medicine. These are on more or less permanent location at Prairie du Chien, and their transport within the state must be very carefully limited because of the problems of packing around the figures and fixtures which were hand-carved out of some type of plaster.

These two acquisitions alone, with a probable value of $50,000 in replacement cost, are vivid illustration of how this Society, through its Foundation, can do much in these days of needed public health education. It is not my purpose here to do other than illustrate this project, but the more recent acquisitions include a bas relief carved in wood of the scene of Beaumont at the bedside of Alexis St. Martin, with a probable replacement value of $1,500 if not more. Today's Health has donated original paintings of health scenes on its covers, and other collections are in the offing if we can but hold to the purpose.

A more recent effort has been to seek donations which illustrate the theme of "Hobbies for Health." Several years ago this House was told of the bequest in the will of R. G. Arveson, M.D., Frederic, of his fascinating collection of more than 300 bells, many of them associated with pioneer physicians and others having historical significance. A collection of postage stamps in health topics has been donated and has been used in various health career efforts.

Why do I mention this in my report to the House? It is because many of you as individuals can provide valuable leads and help in acquiring items in which the collector or his heirs may have lost interest. Provision can be made in the will that these collections come to the Foundation, and since donations are tax deductible, their value is not inventoried for estate purposes.

The long-range policy ultimately to be followed will be to retain that part of a collection which has real value and interest, and to otherwise dispose of items which serve no useful purpose, as duplicates, etc. These collections, displayed at the Museum of Medical Progress and the Stovall Hall of Health, will do much to attract interest there and at other significant historical locations in Wisconsin.

The Foundation is aiding those physicians who through no fault of their own are without adequate funds for their daily needs, and its student loan fund, operated by direct loans as well as through utilizing mechanisms of the AMA, has proved to be a very fine program.

It seems to me that if physicians would keep in mind the Foundation at such times as they wish to commemorate a particular event or express tribute to a deceased associate, the day could well be near at hand when the Foundation's capital would be sufficient to provide for the full-time administration that it deserves; and I think it will be a project of which every physician will be increasingly proud as its efforts keep expanding throughout the state.

MEMBERSHIP REPORT

(See following page.)

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—The Committee acknowledged that the Society had a secretariat of which all members could be justly proud. It complimented the staff of the Society for its cooperation and endless efforts in behalf of all members. It particularly commended the outstanding arrangements made for the Work Week of Health and Health Fads and Fallacies. The Committee realized the task added to the normal burden by the management study group and thanked them for their efforts for the Society. The Committee asked the House of Delegates to concur with it in its belief that a favorable medical climate for establishment of a Zor Shrine Burn Center exists in this state and that it encourage the Shrine to further explore the possibilities in Wisconsin. The Committee recommended adoption of this portion of the report of the Secretary.

HOUSE OF DELEGATES ACTION—Adopted the report of the Secretary as recommended by the Reference Committee.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—It noted that Mr. Earl Thayer had been with the Society for 15 years and that his outstanding support of this Society would be missed. The Committee wished him well in his new enterprise. It recommended adoption of this portion of the report.

HOUSE OF DELEGATES ACTION—This portion of the report was adopted.

ADDITIONAL REMARKS BY THE SECRETARY

There are two faces absent tonight, who have graced our meetings of the House of Delegates, and meetings of the State Medical Society.

One is Charlotte Emmons of Master Reporting Company who, for as long as I can remember, has reported the affairs of your House, and in her quiet way coached the Speakers and Vice Speakers and Secretary on parliamentary law.

The other is Roy Ragatz. Both have had mild heart attacks and we hope they will be back on the job next year.

If I were to attach a title to what I want to say to you tonight on a talk that is unprepared, it would be The Difficulties of Moving Ahead when so much of our time is spent in standing still.

I have been throughout the state and enjoyed meeting in eight of the conferences of delegates and officers, and despite problems of the moment, including that of legislation, and including that of duplicating much material for one reason or another, and particularly for the reason that you will find tomorrow. We have put in hours of work at the staff level, trying to find the time, within ourselves, within the Council and our Committees, to keep moving ahead, for no organization so committed to the public welfare and public health can afford the dangers of standing still.

I have signed a good many bulletins to you as have others of the State Office and our State Officers.

On Bill 131, A., commonly known as the Blue Cross Bill—that bill, as you must know by now, in its present wording would, I think, create the power within Blue Cross to engage in a type of insurance practice that is retail in the personal services, which we think would be dangerous, and inimical to the welfare of the people of this state.

Our opposition to it on behalf of the doctors and on behalf of the members, has been very clearly based on a section of the bill which creates that power, even though Blue Cross has said that it doesn't intend to work in that fashion.

I think, if the Secretary's office has problems, it is sometimes because it does its best to give full and detailed information to the House.

The arguments on that bill in the Senate were heard on May 2. We had a court reporter there. She was unable to produce by this time, the remarks made by the opposition, led off by Mr. Murphy, our Legal Counsel. But she was able to complete the first thirty pages of the transcript which contained all of the remarks in behalf of the Blue Cross Bill.

So, we give to you tonight, at your opportunity to receive it later on, a full transcript of what Blue Cross said, and without the defense. I think it is not only good reading, but informative reading. I think that those of you who may have viewed it rather casually up until now, or who may have said, "We will see what the Council does with it," will find that the Bill is not one which affects the State Medical Society of Wisconsin. Its opposition is not based on that premise. The measure affects the individual physicians of the state, and ways in which you may practice in the future, should Blue Cross be able to retain the power in the present wording.

Appropriate amendments have been placed in the hands of the State Senate, that would permit Blue Cross to engage in these other fields of insurance, but on an indemnity basis, and not on the retailing of individual services.

Going back to the title, I tried to concoct a moment ago, I want to talk about Dr. L. O. Simenstad

MEMBERSHIP REPORT

State Medical Society of Wisconsin

TOTAL MEMBERSHIP BY COUNTY

DECEMBER 31, 1962

County Society	Regular	Resident	Associate	Affiliate	Life	Military	Honorary	Educational	Special Service	Career Appointment	Total
Ashland-Bayfield-Iron	19		1		1						21
Barron-Washburn-Sawyer-Burnett	35	2		1							38
Brown	114		1		1						116
Calumet	7										7
Chippewa	24										24
Clark	14	1									15
Columbia-Marquette-Adams	30		2	1							33
Crawford	8										8
Dane	350	36	9	7	2	13	3	9		9	438
Dodge	39	2	1	1							43
Door-Kewaunee	19										19
Douglas	22					1					23
Eau Claire-Dunn-Pepin	77	1	2	1	3						84
Fond du Lac	66	1			2	2					71
Forest	4			1							5
Grant	28		2								30
Green	34	1	1	1	1						38
Green Lake-Waushara	16	1			1						18
Iowa	11				1						12
Jefferson	31	2	2		1						36
Juneau	5										5
Kenosha	70		4						1	1	76
La Crosse	87	1		6	1						95
Lafayette	7			2		1					10
Langlade	11			1							12
Lincoln	14		2		1						17
Manitowoc	44				1						45
Marathon	64	1		1	1	1					68
Marinette-Florence	16	1	1								18
Milwaukee	1131	102	20	19	15	18	4	4	2	7	1322
Monroe	13				1	1					15
Oconto	7	1									8
Oneida-Vilas	25		1	1							27
Outagamie	80	1	2		2						85
Ozaukee	16										16
Pierce-St. Croix	28	1	1		2	1				1	34
Polk	21	2									23
Portage	26										26
Price-Taylor	10					1					11
Racine	109	1		5	5	1	1				122
Richland	10	1									11
Rock	99	2	3	2	5						111
Rusk	5										5
Sauk	19	1	1	2							23
Shawano	14	1									15
Sheboygan	71		3		2						76
Trempealeau-Jackson-Buffalo	20	1	2								23
Vernon	15		1								16
Walworth	27					1					28
Washington	24	1	1	1	1						28
Waukesha	100	3	1	1	1	2					108
Waupaca	16	1									17
Winnebago	88		1	1	5	1					96
Wood	64				1						65
TOTALS	3304	169	65	55	57	44	8	13	3	18	3736

Members paying no dues		167
Affiliate members	55	
Military service members	44	
Honorary members	8	
Life members	57	
Special service members	3	
Total	167	
Associate members		65
Members in residency training		169
Members paying full dues		3322
Educational members		13
Total		3569
Total membership		3736

of Osceola, an AMA delegate, a man long known to you. It is the ambition of Doctor Simenstad's many friends in the medical profession, those in Wisconsin and in other states, to see him elected to the Board of Trustees of the American Medical Association.

Come the middle of next month, the ballots will be cast, and those contacts that you might have among classmates, friends in other states, could well be used to advise doctors of this man's capacity, of this man's willingness to work, and of his long-time devotion to the medical profession.

You know, a state secretary can't engage in political activity. At least, he can't engage wisely in political activity. The political work, if that is a good term, within the activities of the American Medical Association, must be done by doctors, because it is their association, and I know that we can count on the other AMA delegates.

But, as a staffer, I think I am entitled to say that, within the abilities of our office, the AMA delegation which will meet in Atlantic City, will be fully implemented to promote the candidacy of Doctor Simenstad.

And, just one other remark. The occasion of an annual meeting is an occasion of pride to me. It can't be otherwise.

Well, I guess I had better not talk any more. But when you fight hard, and do as best you know how, in the affairs of medicine, then to come to the root of strength, you can't help but come with pride, and that I have today.

Mr. Speaker, it is my duty to report that, in addition to the Necrology Report contained in the Report of the Council, my office reports the death of:

A. J. Knauf, M.D., Sheboygan,
E. L. Dallwig, M.D., Milwaukee,
J. A. Kelly, M.D., Chippewa Falls,
J. J. Sharpe, M.D., Fond du Lac,
Claude F. Schroeder, M.D., Milwaukee.

(Those in italic were members of the Society.)

■ REPORT OF COMMITTEE ON HEALTH ECONOMICS OF AMERICAN LIFE (HEAL)

Robin Allin, M.D., Madison, Chairman

On April 19 and 20 in Chicago, the American Medical Association held an administrative conference for all the Legislative Committee members from the 50 states, for the purpose of bringing us up to date on federal legislation that concerns primarily medicine. And, out of this federal legislation that concerns us the most at the present time, is the subject of medical care and social security.

In January of this year, Congressman King introduced to the House of Representatives Bill HR 3920, which was referred to the House Ways and Means Committee, where it remains at the present time.

HR 3920 is HR 4422, the King–Anderson Bill with a new number. There are some changes in the bill, but they are not medical changes. We consider that this bill is still compulsory insurance, health insurance for a segment of the population, to be given free to 15 million in our population who have contributed nothing to this insurance to begin with.

It is compulsory. All of these 15 million people at the present time would be eligible for it. That is, hospital and nursing home care, provided they are receiving social security benefits, or railroad retirement benefits.

It has been proved over and over the King–Anderson Bill would now extend that to 2½ million people over 65 who are not covered by Social Security or Railroad Retirement, so they will now be covered from general revenue funds. So, this is the old King–Anderson Bill as dressed up with a new number.

It is now held in the House Ways and Means Committee by a vote of either 14 to 11 or 13 to 12, depending on who got to one of the Congressmen last, and it will stay in the House Ways and Means Committee as long as Chairman Wilbur Mills is still forthright in his determination to see to it that this political hoax is not fostered on the American people. How long he can hold off the Administration is anybody's guess. It all depends on the pressure that is put on him.

But, for the present anyway, it is held there by 14 to 11 or 13 to 12.

But, because of these pressures, the House Ways and Means Committee will call an open hearing the latter part of July, at which time I have been informed by the AMA they will ask for representatives from every state in the Union, from every principal medical society, to present a witness who will bring the House Ways and Means Committee up to date on the progress of Kerr–Mills. Being the co-author of the bill, having the same philosophy that we have, we want to take care of those people over 65 who are in need, and not just because they are over 65, and not just because they are receiving Social Security benefits. Congressman Mills wants to find out what the progress is, and of course Doctor Fox stole my speech again. We are going to have to get together if I ever get up there again. He has already told you about Kerr–Mills. It is implemented now in some 32 states, and some 6 or 7 other states have improved their Old Age Assistance program immeasurably, so that, even in this short period of time, Kerr–Mills legislation has really made greater progress than the original Social Security Bill did, when it was first enacted in 1935.

So there is action, and it is working out very well in the states that have been able to put it in. But we are very anxious to get it in Wisconsin; and, as you have heard from Doctor Fox, this new Kerr–Mills Bill has already been presented to our State Legislature, and it behooves us, gentlemen, and your colleagues, especially you who are personal physicians to your state assemblymen, state senators, to contact them, let them know your position, let them know how anxious we are to see to it that people over 65 who are immediately in need but who are not indigent, will get relief through the Kerr–Mills law.

And that is where we stand at the present time.

I only want to urge you, again, to do all you can to encourage it. The outgrowth of this legislative conference was Operation Home Town, and every president of every county medical society has already received this kit which gives you advice, helps you to disseminate knowledge on Kerr–Mills, disseminate knowledge of medical care through Social Security to your colleagues first. First we must educate ourselves, our families, and friends, our allies and the other professions and to get to all your legislators, even on the local as well as the federal level, so that we can get our message across and preserve our American freedom.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—It thanked the HEAL Committee for its efforts in behalf of the Society. It recommended acceptance of the report of HEAL.

HOUSE OF DELEGATES ACTION—Accepted the report as recommended by the Reference Committee.

ADDITIONAL REMARKS BY ROBIN ALLIN, M.D.

I arise at this time on a point of personal privilege, to speak to you on a non-debatable subject known as WISPAC. WISPAC is the Wisconsin Medical Committee which was born last year, and I must say it flourished quite well in its first year, through your contributions. We have provided many thousands of dollars to the federal legislators of Wisconsin, most of whom were reelected, some of whom were defeated; but at least enough money was provided to have a real impact on our federal legislators, and particularly on the legislator from the Second Congressional District, who was very well aware of our efforts not in his behalf.

This is a year to collect ourselves, to continue our efforts, because it is an election year. It is not a year to sit back and relax. We must have money.

Money talks. We must help people get elected to the state senate, to the state assembly, to Congress, to the Senate, help them with monies to organize their campaigns, help those people who feel the same way we feel about maintaining the present system of free enterprise, and we have to have money.

There are lobbying activities on the part of you and your families and friends. So, I beseech you, please contribute to WISPAC. You have all received notices. I have some extra ones with me tonight. I will be very happy to receive the contributions and save you a five cent stamp. If I don't start hearing from you, I am going to start billing the ones who contributed last year. We must have more money contributed this year. We must have more next year, because WISPAC is here to stay. We are going to grow and we are going to have more impact on legislation.

■ REPORT OF THE COMMISSION ON PUBLIC POLICY—1962–1963

Robert G. Zach, M.D., Monroe, Chairman

While certain characteristics are shared in common by successive state legislatures no two sessions of this body are the same. It is pleasant to be able to report that the present legislature includes an encouraging number of able and energetic members and that the leadership of both parties in the two houses is in the hands of competent and experienced men.

As of May 1 some 1,300 bills have been introduced plus substitute amendments and joint resolutions, a total of nearly 1,500 pieces of legislation. This Commission and the legislative representatives of your Society are closely following about 125 of these bills.

Perhaps the most notable characteristic of this legislative session is its preoccupation out of necessity with fiscal affairs. While such matters are of great moment to the taxpayers and to the business community it remains the responsibility of all citizens to assist legislators in meeting their full responsibilities in such areas as public health. In some situations this calls for the courageous repelling of proposals which would dilute or damage health standards. In others it calls for foresight and a sense of value.

The Council and special committees as well as this Commission have all been active in following the legislative interests of medicine. This activity began many months before the opening of the current session in January, 1963 and will continue without interruption throughout the session.

Over the week end, the Council reviewed a substantial number of bills either for informational purposes or because they involved policy considerations:

1. *Regulation of Blue Plans* . . . Three bills have recently been introduced at the request of the Insurance Commission. They have the net result of subjecting all Blue Plans plus any dental care plans to the same degree of regulation on policy approval, policy content, rates and other vital matters as applies to private health insurance carriers. Bill 627, A. contains the technical changes; Bill 628, A. brings all non-profit Blue Plans under its terms; and Bill 640, A. applies the same regulations to non-profit dental care plans.

The Council is opposed to all three on the basis that such extensive regulation has not been justified either on the basis of experience or public need. Furthermore, it is almost certain to hamper the experimentation through which the Blue Plans have contributed so much to progress in the voluntary health insurance field.

2. *Nursing Bills* . . . Three bills are of special importance in this area.

Bill 524, S. introduced at the request of the State Board of Nursing prohibits the operation of a school for professional or trained practical nurses unless it is accredited by the State Board of Nursing. It would also control correspondence courses for trained practical nurses.

Bill 525, S., also requested by the Board of Nursing, amplifies the Board's powers with regard to standards for schools, prevention of unauthorized practice, reciprocity, examination and re-registration of nurses and trained practical nurses. Representatives of the Society have been in close contact with spokesmen for the Wisconsin Nurses Association and the State Board of Nursing and have participated in various drafts of these bills. It is the judgment of the Council that these bills, with agreed amendments which will be offered to 525, S., are acceptable from the standpoint of the medical profession.

Bill 678, A. would allow a person who has attended a professional nursing school for at least 12 months and who has worked as a nurse in a hospital for two or more years, to be eligible for examination and licensing as a trained practical nurse. SMS OPPOSED because the Council believes that the first year of nurses training is almost totally didactic and not a suitable base for practical nursing.

3. Four bills have been introduced on the subject of chemical tests for intoxication. They are numbered 687, A., 688, A., 692, A. and 693, A. Discussion of these bills is included in the Supplementary Report of the Council.

In addition to the above bills other major legislation is reviewed for your convenience in the summary attached to this report. Of these, two are of great significance to medicine and the public health. The first of these are the twin Kerr–Mills Bills which are numbered 408, S. and 647, A. and which will have a joint public hearing on May 15. These bills provide basic health care for those over 65 who are not public charges but who cannot meet part or all of such expenses.

To assure that the bill will not be administered in the tradition of public welfare legislation there is a mandatory provision that the administration of benefits is to be handled by the Blue Plans or commercial insurance companies. In the previous legislative session a similar bill had general support but was not enacted because of the state's financial position. It is the considered judgment of the Commission, shared by the Council, that the legislature is under the obligation, despite the fiscal problems of the state, of making provision for the health care of this substantial segment of Wisconsin's population. Because this is top priority legislation and because it is truly in the broad public health interest, there is a duty devolving on individual delegates and county society officers to see that every area of the state is represented by one or more spokesman for medicine at the joint hearing scheduled for 2:00 p.m., Wednesday, May 15 in the State Capitol.

A second bill of real significance for the independence of medicine and hence for the standards of public health and the quality of health care is the Blue Cross bill, 131, A. Some of the most objectionable features of the original draft have been met in part by amendments. An amendment has been introduced on behalf of medicine and dentistry which would remove from the bill any Blue Cross authority to contract with physicians or dentists as well as authority to write anything but indemnity contracts with subscribers for other than hospital care. This amendment needs and deserves your support and that of every right thinking physician.

For your convenience a summary of these two bills and a number of others which are particularly important accompanies this report. In addition to those mentioned in the summary the Society is closely watching a "good samaritan" bill (88, A.),

inspection of medical records (499, A. and 700, A.), blood bank services (68, S.), blood insurance (69, S.), State Board of Medical Examiners (513, S.) and public health dispensaries for tuberculosis (371, S. and 551, S.).

SUMMARY OF MAJOR BILLS RELATING TO THE PUBLIC HEALTH

Blue Cross Bill—131, A.

Introduced by Assemblymen Steiger, Oshkosh; Jahnke, Markesan; and Lewison, Viroqua, at the request of Wisconsin Blue Cross. Gives Blue Cross—a corporation—power by contract, and other means to sign up physicians and others and sell their services; also to write and sell a service (full payment) contract for sickness care. This is corporate practice, hiring M.D.'s and fee splitting. The bill has PASSED THE ASSEMBLY. The bill was heard before a Senate Committee on May 30. Nine physicians and three dentists appeared against the bill as drafted. On May 1 an amendment was offered by the Society which forbids Blue Cross to contract with physicians and dentists and limits Blue Cross contracts for sickness care to indemnity (not service). SMS OPPOSED unless this amendment is adopted.

Hospital Regulation—492, A.

Introduced by Assemblyman Terry, Baraboo, at the request of the State Board of Health.

Gives standard setting authority to State Board of Health including regulatory authority over professional personnel in all general hospitals.

SMS has offered an amendment to the effect that the regulatory powers of the Board *not* be extended to physicians and dentists since they are responsible to their respective boards of examiners.

Chiropractic—Three bills are designed to expand the practice or status of chiropractic

Bill 568, A. would legalize their use of the title doctor—SMS OPPOSED.

Bill 559, A. would require chiropractors to attend at least two days of educational meetings annually—SMS OPPOSED.

Bill 516, A. gives county boards the option to make awards *in addition to* Workmen's Compensation benefits to county employees injured while performing services for the county. This might be a backdoor entrance to chiropractic payments for Workmen's Compensation cases, which is now unlawful—SMS OPPOSED.

Basic Science Bill—107, S.

Introduced at the request of the State Board of Examiners in Basic Sciences.

Will add the subjects of bacteriology, biochemistry and hygiene to the four subjects of anatomy, physical diagnosis, physiology and pathology already in the law. Opposition is coming from some chiropractors—SMS SUPPORTS.

Kerr–Mills—408, S. and 647, A.

Introduced by eleven Republican Senators, and the identical bill in the Assembly introduced by Assemblyman Quinn, Green Bay.

Worked out jointly by the Wisconsin Hospital Association, State Dental Society, Wisconsin Pharmaceutical Association and SMS, this bill will implement federal legislation to provide health care assistance to the aged in Wisconsin—SMS SUPPORTS BOTH BILLS.

Radiation Control—247, S. (by the State Board of Health) and 444, S. (by the Industrial Commission)

Provides for regulation of radiation devices. The Board of Health would have authority insofar as physicians, hospitals and others in the health field are concerned. The Industrial Commission would have similar power affecting those devices used in industry—SMS SUPPORTS IN PRINCIPLE.

Psychologists—77, S.

Introduced by Senators Thompson, Stoughton; and Carr, Janesville.

Provides for state certification of psychologists. SMS believes voluntary certification more desirable. If a bill is necessary at all it should clearly define clinical psychology, provide appropriate funds for inspection and enforcement and give certifying jurisdiction to the State Board of Medical Examiners—SMS OPPOSES THE BILL AS PRESENTLY DRAWN.

Optometry—134, A.

Introduced by Assemblyman R. E. Peterson, Waupaca, at the request of the Wisconsin Optometric Association.

Provides that an optometrist's certification of an eye condition shall be conclusive and that his findings and charges shall be accepted on a par with physicians by insurance companies, hospitals, schools, Workmen's Compensation, rehabilitation and Social Security—SMS OPPOSED.

Podiatry—Bill 420, A.

Introduced by Assemblymen Molinaro, Kenosha; and Terry, Baraboo, at the request of the State Podiatrists Association.

Gives chiropody unrestricted right to prescribe and use narcotic drugs—SMS OPPOSED.

"Little FDA Bill"—487, A.

Introduced by Assemblyman Wackett, Watertown, at the request of the Wisconsin Pharmaceutical Association.

Grants the State Board of Pharmacy power to seize drugs and devices that are adulterated or misbranded—SMS SUPPORTS.

Compulsory Retirement of State Employees—146, S.

Introduced at the request of the Wisconsin State Employees Association.

Provides for mandatory retirement of most state employees at age 65—SMS OPPOSED.

Major Illness Insurance for the Aged—300, A.

Introduced by fourteen Republicans.

Permits insurance companies in Wisconsin to "pool" offerings of catastrophic insurance for persons age 65 and over—SMS SUPPORTS, but urges adoption of amendment to include Blue Plans in such joint offerings.

Prepaid Prescription Plans—264, S.

Introduced by Senator Rasmusen, Spooner.

Authorizes the establishment of non-profit prepaid prescription drug plans by or through the Wisconsin Pharmaceutical Association—SMS SUPPORTS.

Mental Health Bills

At least 20 bills reflect the growing interest in the area of mental health. Committees of the State Medical Society have given preliminary study to most of them and the Society has taken a firm position on 5:

Bill 309, S.—Introduced at the request of Judge Francis Wendt, Racine.

Permits one licensed physician to apply for mental examination of a patient in addition to granting the same authority to three adults—SMS OPPOSES on the basis that it is preferable to have the full cooperation of the immediate family and others close to such a patient.

Bill 310, S.—Introduced by request of Judge Wendt.

Allows examining physicians to certify the mental condition of a patient rather than file an affidavit—SMS SUPPORTS.

Bill 311, S.—Introduced by request of Judge Wendt.

Applies the certifying mechanism (rather than the affidavit) to the report of a physician's examination for mental deficiency—SMS SUPPORTS.

Bill 313, S.—Introduced by request of Judge Wendt.

Allows treatment of a person temporarily committed to a county hospital. Such treatment is now allowed only in state hospitals for the mentally ill—SMS SUPPORTS.

Bill 315, S.—Introduced by request of Judge Wendt.

Permits the discharge of a mental patient by the superintendent of any county hospital upon written recommendation of its medical director or visiting physician, and with the approval of the Department of Public Welfare. At present this authority is limited to Milwaukee County—SMS SUPPORTS.

With regard to the remainder of the bills the State Medical Society has suggested to the Legislature the desirability of a study to up-date the entire Mental Health Act (Chapter 51 of the Statutes) instead of taking the piecemeal approach. The bills recommended for further study are:

Bill 167, S.—Interstate compact on mental health—SMS suggests that an Attorney General's opinion be obtained as to whether the bill is constitutional in form and adequately protects the rights of the patient.

Bill 169, S.—Relating to admission, retention and discharge of mental patients.

Bill 170, S.—Relating to financial provisions of the Mental Health Act.

Bill 174, S.—Relating to fiscal aspects of maintenance, charges and hospital costs under the Mental Health Act.

Bill 306, S.—Relating to certification of vacancy for mentally deficient persons.

Bill 307, S.—Relating to family care of mental patients.

Bill 308, S.—Relating to notice of hearing upon application for successor guardian.

Bill 312, S.—Relating to jury trial for a person alleged to be mentally ill.

Bill 314, S.—Relating to inebriates and drug addicts.

Bill 316, S.—Relating to out-patient care of mentally ill patients.

Bill 331, S.—Relating to continuation of the Mental Health Advisory Committee and extending its functions to include alcoholism.

Bill 370, S.—Relating to conditional release, and return of escaped mental patients.

Bill 383, S.—Relating to the rights of hospitalized mentally ill patients to the highest standards of treatment.

Bill 385, S.—Redefining "mental illness" and "county hospital."

Bill 386, S.—Relating to commitments to private facilities.

In urging the Legislature to do a thoroughgoing study of these bills in relation to the Mental Health Act Dr. N. A. Hill, President of the Society, said: "I cannot help but think that it would be better to weigh the proposed changes against the overall pattern and philosophy of such an important law instead of hoping that no one change would cause unintentional dislocation of some other equally important and needed portion of the total legislative machinery for mental health care."

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—The Committee noted that the Commission had spent many hours of work, both before the legislative session and throughout the present session, and had requested the assistance of physicians in the state in the upcoming joint hearing on May 15 on the Kerr–Mills implementation bills. Because this is top priority legislation and because it is truly in the broad public interest, the Committee expressed its belief that there would be a marked benefit of having physicians present if only to register their presence, if not to testify.

In light of the intricacies of the many bills under discussion, the Reference Committee urged that the delegates read and understand the report of the Commission in its entirety. It further urged that the Commission consider the establishment of subcommittees to assist it in serving the public health interest in specialized areas.

The Reference Committee recommended acceptance of this portion of the report.

HOUSE OF DELEGATES ACTION—Accepted the report of the Commission on Public Policy as recommended by the Reference Committee.

■ REPORT OF STATE HEALTH OFFICER —1962–1963

Carl N. Neupert, M.D., Madison

For me, this is quite an occasion in that, now for 21 years in succession, you have extended an invitation to come before you at the annual meeting of the House of Delegates. To make it worth your while in your heavy schedule it's quite a challenge to respond to the invitation to "report on the affairs of the State Board of Health" in let's say about three to five minutes.

Over these years, the State Medical Society—that includes nearly all of the practicing doctors of medicine in the state—and the State Board of Health have cooperatively been responsible for many significant accomplishments in advancing the health and life of citizens. You have listened to me cite many of them on these occasions. Tonight, in the time available, let me briefly refer to some of the problems that confront the State Board of Health and are of concern to you as citizens and as physicians.

As many of you know, we've had reported for the first four months of this year over 15 times as many cases of measles as were reported last year during the same period, and as a result have, for the first time in a decade, exhausted our supply of gamma globulin supplied to us by the American Red Cross.

On the other hand, last year's total of 9 cases of paralytic polio is 100 times less than our high of 974 cases in 1955 just before polio vaccine came into general use. We haven't time to go into the Salk Vaccine era nor that of the new Sabin Oral Vaccine now available, but that dramatic, wonderful result was not achieved by accident. You, as physicians, administered practically all of the vaccine and we were in there working out the preliminary field trials and alerting people and motivating them to take advantage of this wonderful protective measure.

But, let me get to some problems that confront the Board. For instance, for far too long we have had to do our best to fill in as we could in the four of the eight districts covering the state in which there is a vacancy in the position of District Health Officer. We still have three public health physician vacancies in our central office as well. We're trying, but we could do much better and be of so much greater help to you if we had those public health physician vacanices filled.

With reference to this problem, we're occasionally asked "why can't you take advantage of the possible instances in which practicing physicians in the older age groups or who are about to retire who might be interested in entering public service by employing them?" It would be a great help if that were possible, but there is an age 65 retirement provision in the statutes and postgraduate training in public health administration is necessary to directing activities of public health nurses, sanitary engineers and sanitarians, nutritionists, and others that are necessary to make up the public health team to do the job.

Among other problems there is a recent trend or whatever it should be called that is of concern to us —namely, an undefined feeling of lessening of confidence or of rapport wherein the State Society raises questions as to the motives of its governmental health agency cooperator, in such areas as screening tests of the apparently well as provided in the 3 x-ray survey busses and in the area of laws and regulations. Expressions come to us such as "a foot in the door" or "what assurance is there that in years to come there couldn't be a reconstituted Board that would be power hungry and that would proceed to interfere with the sound practice of medicine to the detriment of progress in advancing the health of people?"

Certainly anyone has the right to question the motives or actions of a governmental unit such as the State Board of Health, and if there is basis for action it is his moral duty along with others of the same opinion to take whatever action is indicated. There are safeguards such as through legislative action or action through the courts, by way of public hearings, etc., that can be brought to bear on any such problem, should this become necessary.

On the other hand, let me assure you that the Board is well aware of the potential of advancement of the health of people through the private offices and services rendered by 4,000 practicing physicians in the state. Not too many years ago, among the activities carried on by the Board, there was that of sponsoring and providing prenatal clinics. When expectant mothers were convinced that this service could be better done in the physicians' offices and physicians provided it, the clinics were discontinued. You know how, during—a few years later—the EMIC days (Emergency Maternal and Infant Care for servicemen's families during World War II) we, as a state, were well beyond standards set for the nation in prenatal care, and you know, too, how well we still rank among states in low maternal mortality rates. These are among your accomplishments as practicing physicians in advancing the health of our people.

Other examples could be given, but let's get back to this concern over laws and regulations. If there is sound basis for questioning, say a maternity hospital regulation, be assured that a written petition would result in a thorough public hearing at which any who wished could appear and everything presented would be carefully and thoroughly considered by the Board in arriving at its decision.

As for legislative matters, no state agency should have authority beyond need to protect the public, but where such a need exists it is better to place responsibility for it in one agency than to have it dealt with piece-meal by several. Over the 87 years that the Board has been charged with responsibility for "general supervision throughout the state of the health and life of citizens" to quote the original and still current statutory provision, it has not gone haywire. The Board has consistently taken its responsibilities very seriously, and I am confident that it will continue to.

My time is up and if your interest has been piqued, it may have served a purpose.

■ REPORT OF STATE BOARD OF MEDICAL EXAMINERS—1962–1963

T. W. Tormey, Jr., M.D., Madison, Secretary

I, too, wish to thank you for the opportunity of presenting briefly but factually, and I hope informatively, the activity of the Board of Medical Examiners for the past year.

As a follow-up to last year's report to you, I believe that several items should be brought to your attention.

The foreign graduate program with its inquiries, screening, licensing and placing has reached its peak. We find ourselves in the position now of having only two more vacancies we may fill this year. This brings up the question of whether this particular effort should now be enlarged or expanded to allow more such physicians to obtain their licenses in Medicine and Surgery in Wisconsin. Consideration is being given such a move and conferences with other responsible and interested parties will no doubt be planned.

A recheck of the whereabouts of the 60 licensed foreign graduates detailed to you a year ago indicates that of the 41 in their original locations 36 are still there. Of the 8 who had moved to another location, 8 still remain. Eleven others had moved to other states or never did settle in Wisconsin and their number is now 15. One is deceased.

You are aware that this state allows one postgraduate year of approved internship, here or elsewhere, but beyond that year physicians must be licensed whether in private practice, or doing residency work. We make an annual survey of all hospitals approved for residency training and obtain the preliminary data on the new individuals going into these positions. Primarily for the convenience of the new resident physicians who do not hold a Wisconsin license, the Board has taken the position that these physicians be granted the opportunity of obtaining their licenses at the next nearest meeting at which they are qualified to appear. Many of these doctors come from across the continent and would find it extremely difficult to start a residency on July 1st and be expected to meet the Board on the second Tuesday in July. Because some individuals have taken advantage of our leniency we have adopted a more positive approach to the situation.

Along with the changes in the type of residency training being developed in the past few years, i.e., the rotation of training from one hospital to another, the question of need for licensure by any physician working in municipal, county, state or private hospitals has been brought up. You probably know that, as a state, we have no jurisdiction over the trainees in or the policies of the federal institutions. However, resident physicians in the Veterans facilities are on the rotating training programs in our state, county and private hospitals. In view of this last, we have an opinion from the Attorney General's office, stating that such individuals must be licensed in Wisconsin if they are to take any of their training in other institutions involving private citizens. The interested parties have now been so notified.

In the 1962 directory of approved internships and residencies Wisconsin, aside from those in the Veterans facilities, is listed as having 397 approved residency positions available. There were 328 nonforeign and 108 foreign physicians in these programs. As you can readily see, considerable checking must be done to keep up to date in this area.

Last year, we issued licenses in Medicine and Surgery to 327 individuals, 304 males and 23 females.

Violations of the Medical Practice Act have had our attention. In this past year, Mr. Pressentin has checked 11 MD's and DO's, 18 quacks, 2 podiatrists, 2 masseurs, and 3 chiropractors. Two successful injunctions were obtained against faith healers, 2 criminal prosecutions are ready for trial, 2 injunctions are being prepared, there was 1 surrender of license, 3 surrenders of narcotic permits, and there have been 25 follow-up investigations.

This year so far, we have registered a total of 6,721 individuals. This is 547 more than last year at this time.

Breaking this group down into in- and out-of-state groups, we will find 5,789 M.D.'s; 239 D.O.'s; 505 Physical Therapists, and 188 Podiatrists.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—It acknowledged the report of Doctor Neupert and his statements with regard to the public health employee situation in the state as well as other problems of his department. It also acknowledged his twenty-first consecutive year of appearing before this House, complimented him on his service to medicine and public health as well as his attendance record.

HOUSE OF DELEGATES ACTION—Accepted the report of the Secretary of the State Board of Medical Examiners as recommended by the Reference Committee.

■ REPORT OF THE DIVISION ON CHEST DISEASES—1962–1963

H. A. Anderson, M.D., Stevens Point, Chairman

This Division, originally concerned exclusively with problems of TB care and prevention, now serves in an advisory capacity to the State Board of Health and other agencies, in respect to the State Board of Health hypertension program and other projects associated with chest diseases, but not exclusively in the area of tuberculosis.

In previous reports of this Division, county medical societies have been urged to cooperate with the State Board of Health in the expansion of its mobile screening program, to include early detection of hypertension in unsuspected cases. Initially, there was considerable misunderstanding and resulting physician opposition to this program. Since its introduction in 1958, some of the original procedures have been revised, and there has been greater utilization of this service throughout the state. The Division again wishes to emphasize the public health values of this program and to remind physicians that its results to date have revealed many unsuspected cases of hypertension which could be assisted with resulting medical care. The last report on this program, presented to the Division in January 1963, is worthy of review by all members of the House of Delegates.

The Rapid Hypertension Screening Program (1958–1962)

Since it was initiated in July of 1958 as a second component in the State Board of Health Mobile Unit Survey, the Rapid Hypertension Screening Program has gradually gained acceptance as an effective public health case finding procedure (both by the lay public and physician). This acceptance has been reflected both in the proportion of persons x-rayed who are also being screened for possible hypertension and also in the increasing number of county medical societies who have approved of the program being conducted in their areas.

In its first full year of operation (1959) thirteen of the twenty-three medical societies who were routinely approached, approved to have hypertension screening conducted in addition to chest x-ray screening. The proportion of those societies approving this screening procedure has increased steadily and in 1962, 19 of 24 societies approved of the program. As of January 31, 1963, 13 of 15 societies scheduled to be visited by the State Board of Health Mobile Unit will have hypertension screening. Of the 64 county medical societies who were offered the hypertension program, more than two-thirds of these societies gave their approval.

During the first one and one-half years of operation, of 267,000 persons x-rayed, approximately 97,200, or 36.5%, were also screened for hypertension. This proportion has likewise shown a progressive increase and as of July 1, 1962, the proportion of those x-rayed who were also screened for hypertension had increased to 62.5%.

Of the first 100,000 persons screened for hypertension between July of 1958 and December, 1959, about 10% were referred to their respective physicians for follow-up. . . . 68% of those referred visited their respective physicians and of this number 70.2% were confirmed as having either hypertension or some other form of heart disease. At this time all persons with an abnormal screening blood pressure (160mm Hg systolic and/or 100mm of Hg diastolic) were referred to their physicians, regardless of a previous history of heart disease. In 1960, a major change in policy was enacted in which only those persons with a negative history of heart disease (as recorded in their registration cards) and an abnormal screening blood pressure would be referred to their physicians for follow-up. On the basis of approximately 79,000 persons screened for hypertension under this new policy, the referral rate has been reduced by about 50%. The follow-up and the confirmation rates remained in the vicinity of 70–75%. Data on an additional 141,000 persons screened for hypertension up to June 30, 1962, are available and being analyzed.

The success of any case finding program is usually determined by the number of new cases that it uncovers. Recent special study designed to determine the new case yield rate of the hypertension program showed that almost two out of every five cases of confirmed hypertension are considered new by the diagnosing physician.

From the above statistical facts the Division feels that this program has value and deserves support and understanding of the profession. It is hoped that more county societies will cooperate with the State Board of Health and utilize the findings of the mass screening in their area, for improved care of their patients, or individuals who present themselves as patients as a result of screening tests which indicate they might have a problem of hypertension requiring medical attention.

Rheumatic Fever Diagnosis and Treatment

The Division has been kept informed on the experience of the State Laboratory of Hygiene in its pilot program to identify the extent of Group A hemolytic streptococci, and to quickly report all positives to physicians so that prompt treatment can be employed. The results of the two-year report are significant, and one which suggests the value of this program becoming an integral part of the services of the State Laboratory, and providing such services to all physicians in the state. On the basis of two years of testimony (in 1961 and 1962) some 52,000 specimens have been studied, with over 9,000 identified as being in Group A. It is the hope of the Division that the State Laboratory of Hygiene will be successful in securing additional state funds to continue this program, and to extend the services to all Wisconsin physicians. If this is accomplished it is urged that physicians who are members of the State Medical Society avail themselves of this valuable diagnostic procedure.

Another facet of rheumatic fever and its associated health problems has been the recent move to transfer the prophylactic bicillin program from the Bureau of Handicapped Children to the State Board of Health, and to possibly expand the services beyond the 21 year age limit, which is the upper age available for service through the Bureau of Handicapped Children. The Division on Chest Diseases has been given a report on this proposed transfer of services, and urges that if this is done all physicians who have patients needing prophylactic care ascertain the services of the state program. It is important to emphasize in this regard that the program, both as originated under the Bureau of Handicapped Children and to be carried on through the State Board of Health, is restricted to patients *in financial need.* Family physicians are in a position to know if daily costs of drugs at regular prices would impose a financial hardship on the individual or the family, and if such is the case the state program is prepared to assist by way of providing drugs at either a markedly reduced price, or entirely free of charge if the situation suggests such complete service.

Skin Tests for TB

Numerous claims have been made for an improved skin test for the detection of tuberculosis. This subject is one of major concern to the Division, and its views on this, as of this date, are as follows:

> "Since the preliminary report on the use of the Tine Test for tuberculosis skin testing a study including 10,000 simultaneously administered 5 T. U. Mantoux and 5 T. U. Tine tests on each arm has been completed.
>
> The results show significant differences between the two tests and indicate the need for much more extensive studies before the Tine Test can be recommended for diagnostic and screening use in place of the standard intradermal Mantoux.
>
> The previous recommendation against the use of the Tine Test except in experimental studies is reiterated."

Tobacco Advertising and Exhibits

Members of the Division on Chest Diseases are in agreement that there is sufficient scientific evidence establishing a relationship between the habit of smoking and lung cancer (as well as adverse health experience of patients suffering from heart disease) to suggest that policy consideration be given to the elimination of tobacco advertising in the Wisconsin Medical Journal and the continuance of tobacco exhibits at the Annual Meeting of the State Medical

Society of Wisconsin. It has been the recommendation of the Division that the Council and the House of Delegates establish a policy in reference to tobacco advertisements and exhibits which will conform to the current policy of the American Medical Association in regard to tobacco advertising and exhibits.

TB Case Finding in School Children

While the incidence of active tuberculosis, unsuspected, among school children is commendably low, isolated cases have resulted in an "explosion" among the school children exposed to such active cases. It is urged that local health councils consider the promotion of voluntary tuberculin testing programs. Those immediately concerned with the implementation of the President's Physical Fitness Program might well consider the health examination of school children to include a Mantoux test.

Routine Chest X-Rays and Insurance

It has been demonstrated that routine chest x-rays of all patients admitted to hospitals reveal a significant degree of chest pathology. Because of this it is hoped that the insurance programs in Wisconsin will give careful attention to the possibility of providing such coverage either as a basic form of the policies sold, or as riders to existing policies.

Centralized Care and Dispensary Services

The 1961 House of Delegates charged the Division on Chest Diseases to initiate a comprehensive study of the tuberculous in Wisconsin, and to consider the content of a resolution submitted by Douglas County expressing the advisability of discontinuing care in many of the existing institutions, and possibly erecting two or three new facilities which would serve the entire state and concentrate care in the area of tuberculosis alone.

At the 1962 Annual Meeting the Division reported that the State Board of Health was initiating a study of TB care in Wisconsin, and the House directed the Division to keep itself informed as to the results of this study, and to report back to the House of Delegates in 1963.

The Division has been directly associated with the study of the State Board of Health through representation of two members of the Division. Many meetings have been held to review existing experiences in county institutions caring for tuberculous patients, the shifting case load due to the use of new drugs, and the advisability of centralizing care facilities.

Because the operation of county institutions is outside of the province of the State Board of Health the State Board has little or no authority to implement any recommendations.

In reviewing the current experience in institutions offering treatment for TB, and recognizing the change from bed care to ambulatory care (with the necessity of medical evaluation outside of hospital service) the study of the State Board of Health concluded that centralization of service might best be achieved through the withholding of state aid to institutions failing to maintain a TB census of less than 20 persons. At the same time the study recognized the need for development of out-patient dispensary services (not necessarily associated with hospitals), where the TB case load on an area basis is sufficient to suggest such out-patient service. The study has been implemented in proposed legislation which would encourage discontinuance of TB services where fewer than 20 patients are being served, and to encourage the development of out-patient dispensaries to serve referred patients being treated in an ambulatory manner.

The Division concurs in the views of the State Board of Health study committee that the erection of new facilities for the care of TB patients alone, as suggested in the Douglas County resolution of two years ago, is unrealistic, and that efforts should rather be made to centralize services in existing institutions, and encourage the development of out-patient dispensaries for ambulatory care, either as an adjunct of current facilities, or as separate services. It is recognized that in certain sparsely settled areas of the state dispensary services might have to be provided through the agency of the State Board of Health itself, rather than through the county.

After careful study the Division makes the following recommendations:

1. That support be accorded proposed legislation which would withhold state support from institutions which fail to maintain a TB patient load of not more than 20 persons.
2. That in areas where county dispensaries are established to render *referred* out-patient services to known cases of TB and related pulmonary diseases the county society take an active role in establishing rules for the operation of such out-patient dispensaries.
3. That support be accorded the development of out-patient dispensaries for known cases of TB and other pulmonary diseases, either through the county, if the population exceeds 25,000, or through the State Board of Health, where need exists and county services are not provided.

DIVISION ON CHEST DISEASES
H. A. Anderson, M.D., Stevens Point, Chrm.
George C. Owen, M.D., Milwaukee
Warren K. Simmons, M.D., Rhinelander
John H. Wishart, M.D., Eau Claire
George R. Barry, M.D., Monroe
J. Richard Johnson, M.D., Madison
George E. Magnin, M.D., Marshfield
John Rankin, M.D., Madison
Raymond H. Evers, M.D., Plymouth
John H. Huston, M.D., Milwaukee

■ REPORT OF THE DIVISION ON HANDICAPPED CHILDREN—1962–1963

J. W. Nellen, M.D., Green Bay, Chairman

The Division, as advisory to the Bureau of Handicapped Children of the Department of Public Instruction, has been in constant touch with the Medical Director of the Bureau as problems have arisen, and the Division is pleased to make the following report on specific health programs conducted under the auspices of the Bureau this past year:

Orthopedic Clinics

Adhering to the current policy of providing clinics only where counties request such services, and not conducting clinics in counties where orthopedic services are available and it is the will of the county society to render services through the individual orthopedist's office, a total of 1,550 children were seen in 14 clinics. An additional 381 children were examined in the offices of individual physicians. While this program is not as extensive as years ago, when orthopedic services were lacking in most areas outside of Milwaukee and Madison, there is still an expressed desire for clinics in various parts of the state and the program is being conducted under proper medical supervision by the Division and the cooperating county medical societies.

The Division feels that this program has value so long as it helps the family physician to meet specialized problems, and where the county medical society expresses a wish that the clinic service be continued.

As a correlary of this medical program, it is interesting to note that 761 children are now enrolled in 12 orthopedic schools in the state, and an

additional 314 students are served as out-patients. The number of children attending orthopedic schools has gradually declined since peak attendance of 1,389 in 1946–47, with the exception of 1955–56 when 1,304 children were served by the special schools.

Hearing Conservation Program

This past year 185,000 children were screened for hearing defects, and 1,450 were examined in special otologic clinics for further evaluation of hearing problems. This program has been carried on for many years, and is well accepted throughout the state. Close relationships are retained between the physicians conducting the clinics and the family physicians, so that children in need of special care can be properly guided by their family physician.

Bicillin Prophylaxis Program

Continuing this program on the basis of physician recommendations, and restricted to families in need of financial aid, 1,236 children have been receiving prophylaxis at reduced cost this past year. In addition, 80 children with cardiac problems have been receiving homebound instruction, and an additional 28 children with cardiac problems are receiving services in orthopedic schools.

Cleft Palate Program

A total of 299 children have received assistance in this area during 1962. This includes children seen in the cleft palate clinic at the Wisconsin Orthopedic Hospital in Madison. As in other programs of the Bureau, those rendering special services work closely with the family physician, so that the child served can be properly evaluated and followed in his home community to be sure that maximum recovery is achieved.

The above programs have been reported to the Division, and the Division is pleased to report that few problems with physicians have arisen this past year. There is now a better understanding of the operation of the bicillin program, and other services as outlined are being conducted on a request basis, either by approval of the county medical society or by direct request of the family physician.

The Division sees little cause for concern, so long as the present medical policies of the Bureau are maintained.

DIVISION ON HANDICAPPED CHILDREN

J. W. Nellen, M.D., Green Bay, Chrm.
George H. Handy, M.D., Wisconsin Rapids
James E. Miller, M.D., Madison
Lloyd P. Williams, M.D., Appleton
Robin Allin, M.D., Madison
Donald A. Jeffries, M.D., Shawano
F. D. Bernard, M.D., Madison
R. C. Waisman, M.D., Milwaukee

■ REPORT OF THE DIVISION ON MATERNAL AND CHILD WELFARE—1962–1963

John R. Evrard, M.D., Milwaukee, Chairman

The Division is pleased to report continued cooperation of the profession with the Maternal Mortality Survey, and calls attention to the report of the Commission on Scientific Medicine, listing two Maternal Mortality Institutes as contributions to the postgraduate teaching program of the Society this past year. The Division feels that the Wisconsin Maternal Mortality Survey is one of the finest programs of its kind in the country, and the 16 teaching programs conducted by the Survey Study Committee since 1958 indicate how the educational objectives of this continuing research project of the Society are being attained. It should interest the House that these programs to date have been attended by 2,068 persons, including 1,102 physicians, and the balance hospital personnel.

As an outgrowth of the Maternal Mortality Survey, the Division has developed a special nurse training program which it is hoped can be expanded to be of assistance to smaller hospitals in the state. It is recognized that hospital personnel is often called upon to carry out many of the functions of a physician as an emergency procedure in deliveries, and there is need for additional training of a nurse who can be of special assistance to physicians. To help meet this need a short, intensive nurse training program has been conducted at St. Joseph's Hospital, Milwaukee, and it is hoped that with the cooperation of several other hospitals a continuing "circuit" type of instructional program can be carried out, so that all of the smaller hospitals in the state can avail themselves of this service, and have one of their nurses given special instruction so that nursing assistance to physicians in the care of obstetrical patients can be maintained at the high level necessary to properly meet all obstetrical emergencies.

Prematurity continues to be a problem, in Wisconsin as in other portions of the United States. The Division plans to continue emphasis on this problem through special teaching programs for physicians and hospital personnel, conducted cooperatively with the Bureau of Maternal and Child Health of the Wisconsin State Board of Health.

As an outgrowth of the Maternal Mortality Survey, a special emphasis has been directed to the use of oxytocics in the induction of labor. Because there have been repeated questions raised concerning the views of the Division on this subject, it appears appropriate to re-state the opinions of both the Maternal Mortality Study Committee and the Division on Maternal and Child Welfare on this important procedure associated with delivery. Because a significant number of maternal deaths appear to be associated with the administration of oxytocics, the Division feels it important to direct attention of individual physicians and hospital staffs to this specific phase of medical practice:

The Use of Oxytocics: Views of the Maternal Mortality Study Committee

"Since 1953, the State Medical Society of Wisconsin has conducted a Maternal Mortality Survey, through which each maternal death in the state has been carefully studied. As an outgrowth of this continuing survey, members of the Maternal Mortality Study Committee have, on numerous occasions, expressed their concern over the number of deaths attributed to ruptured uteri, which in turn seem related to use of oxytocics."

On several occasions individual physicians and groups of physicians have expressed disapproval of a current rule of the State Board of Health which reads as follows:

> "H26.063 (2) OXYTOCICS: Nurses and other non-medical personnel shall not administer oxytocics to antepartum patients unless a physician is present."

In light of frequent adverse comments concerning this rule, and a common misconception concerning views of the Maternal Mortality Study Committee, it seems appropriate for the Committee to clarify its position and recommendations concerning this important subject. It is hoped that hospital staffs will give thoughtful consideration to the content of this statement, and implement it in a manner which will provide needed and complete protection to obstetrical patients.

1. *THE STUDY COMMITTEE DOES NOT MAKE RULES:* The Maternal Mortality Study Committee has no authority to make rules, nor does it desire to do so. The Maternal

Mortality Survey is an *educational* project, and all the Study Committee seeks to do is set forth recommendations, which it is hoped can be translated into workable and protective rules of hospital staffs, *upon action of hospital staff members.*

2. *ITS VIEWS ON THE PRESENT RULE OF THE STATE BOARD OF HEALTH:* The Maternal Mortality Study Committee recognizes the fact that there are varying views on whether or not the State Board of Health has, or should have, powers which permit the enunciation of a rule concerning the administration of oxytocics. However, it should be pointed out that when the current Administrative Code was being revised five physicians from the State Medical Society were associated with the revision, and the rule under question was approved by them, and made a part of the Code, after all county medical societies and hospitals had been notified of the public hearing where the provisions of the proposed Code were presented.

   Whether or not the State Board of Health, or any state agency, has powers to regulate the practice of nursing is a point which cannot be determined by the Maternal Mortality Study Committee. However, in the opinion of the Maternal Mortality Study Committee, the implementation of the procedure, whether in the form of a rule or a recommendation, is one which is valid and deserving of support. In the opinion of the Maternal Mortality Study Committee, the administration of an oxytocic is a medical procedure, and one which should not be delegated to a nurse without immediate supervision of the physician. It cannot be properly related to procedures commonly performed by nurses without direct medical supervision, as the agent being employed is one which can, and does on occasion, produce an adverse reaction which requires *immediate medical attention.*

   It is furthermore the opinion of the Maternal Mortality Study Committee that "*medical* supervision" is essential, to meet medical emergencies when they arise. This does not mean that the attending physician must be at the bedside until labor is achieved, nor does it mean that he cannot leave the hospital IF *ADEQUATE, MEDICAL* COVERAGE IS AVAILABLE IN THE HOSPITAL AND KNOWN TO THE NURSE OBSERVING THE PATIENT. By "adequate medical coverage" the Study Committee means a physician well enough versed in obstetrics to properly handle medical emergencies commonly resulting from adverse reactions to administered oxytocics. Rules of hospital staffs should be formulated to meet this objective, in light of local conditions and local professional resources, but the Maternal Mortality Study Committee does not feel that it is proper for the medical profession to push nurses into areas of medical practice which are beyond their scope of training.

3. *IV OR INTRAMUSCULAR ADMINISTRATION OF PITOCIN:* In event it is the decision of the attending physician to administer Pitocin for induction of labor, it is the recommendation of the Maternal Mortality Study Committee that IV administration be employed. The intramuscular administration of Pitocin is exceedingly dangerous, as there is no way of stopping its action if a reaction is experienced by the patient. Intravenous drip is a much safer procedure, and permits the observing nurse and the physician to discontinue its administration in the event of an adverse reaction.

   Suggested dosage: The more dilute solutions of Pitocin are more easily regulated as to drops per minute; for example, ten units per thousand cc. would be two times as concentrated as five units per thousand cc. In the first instance if ten drops per minute were required to produce a given result, then twenty drops per minute would be required in the second or more dilute dosage, and this could be much more easily regulated. It is therefore recommended that the more dilute solutions be employed.

4. *THE ROLE OF "TOCOSAMINE" IN THE INDUCTION OF LABOR:* A recent drug marketed under the trade name of "Tocosamine" has been widely advertised as being an ideal oxytocic, without any of the hazards experienced with Pitocin. The Study Committee cautions physicians that this drug is still classified as an oxytocic, and is subject to the same current regulations as all other drugs used for induction of labor. While limited experience has indicated that this drug may have certain safeguards which make its use desirable, there is still insufficient evidence in the literature to suggest that it can be employed in a manner differing from other classified oxytocics.

The Maternal Mortality Study Committee wishes to re-emphasize that it is not telling physicians how to practice medicine. It does, however, feel obligated to call attention to certain dangers which have revealed themselves in the Wisconsin Maternal Mortality Survey, and to urge hospital staffs to establish local staff rules which will give assurance of protection to the obstetrical patient, and to give the patient assurance of *medical* care in situations which will require medical judgment. The nurse is a valued "partner" of the physician, but she has not been trained to meet medical emergencies, and she should not be encouraged to exercise medical judgment. Should the medical profession neglect to provide proper medical supervision of nursing activities, and fail to provide medical care of patients in times of obstetrical emergencies, it is failing to carry out the professional obligations which it has accepted through the licensing branch of the state government.

All the Maternal Mortality Study Committee wishes to do is to ask hospital staffs to recognize the real and recurring problem, and to establish local regulations which will provide the obstetrical patient with proper *medical* coverage at all times.

The Division is appreciative of the cooperation of the profession both in respect to the Maternal Mortality Survey and all other programs provided by the Division in areas of maternal and child health. To Division members there seems to be an increasing awareness of special pediatric and obstetrical problems as they arise and a commendable desire on the part of physicians to receive advice and assistance which can be translated into improved care of their patients. The continued cooperation of the physicians in the state with the State Board of Health has created a climate which encouraged cooperative efforts in these important areas of medical practice, and the Division is pleased to be the vehicle by which teaching pro-

grams in pediatrics and obstetrics are provided as a service to Society members.

Division on Maternal and Child Welfare
John R. Evrard, M.D., Milwaukee, Chrm.
E. A. Birge, M.D., Milwaukee
S. L. Griggs, M.D., Green Bay
K. J. Winters, M.D., Wauwatosa
F. G. Johnson, M.D., Superior
George H. Stevens, M.D., Wausau
J. D. Wilkinson, M.D., Oconomowoc
Lloyd J. Steffan, M.D., Plymouth
Richard C. Brown, M.D., Eau Claire
William R. Kreul, M.D., Racine
T. A. Leonard, M.D., Madison
B. P. Waldkirch, M.D., De Pere

■ REPORT OF THE DIVISION ON NERVOUS AND MENTAL DISEASES—1962–1963

Keith M. Keane, M.D., Appleton, Chairman

The Division was well represented at two American Medical Association Conferences during the past year, devoted to interpretation of the AMA Mental Health Program and designed to encourage implementation on the state level. Many of the Division's activities during the year have been within the context of this program.

A major concept of the program is to provide base treatment, where possible, at the community level and increase the role of the non-psychiatric physician in the treatment of the mentally ill.

Mental Health Steering Committee

As an outgrowth of the 9th Annual Conference of Mental Health Representatives of State and County Medical Societies, sponsored by the American Medical Association, March 1–2, 1963, and attended by several representatives of the Division, it is recommended that the State Medical Society take the leadership in formation of a Steering Committee on Mental Health. This Committee would have representation from both medical and non-medical organizations and governmental units.

Such a Committee would be in conformity with the American Medical Association's hopes for stimulating medical leadership in mental health. The Division believes it would be desirable as a means of establishing across the board liaison between the many organizations and interests concerned with mental health. It is recommended that the Division, with the approval of the Commission on State Departments, create such a Steering Committee with representation from the Division, Wisconsin Academy of General Practice, Wisconsin Pediatric Society, Wisconsin Psychiatric Association, Wisconsin Society of Internal Medicine, University of Wisconsin Medical School, Marquette University School of Medicine, Wisconsin Mental Health Association, Wisconsin Council for Retarded Children, Wisconsin Psychological Association, Wisconsin Sociological Association, the clergy, Wisconsin League for Nursing, physician representing Wisconsin institutions, Division of Mental Hygiene of the State Department of Public Welfare, Council on Higher Education, Wisconsin Rehabilitation Association, County Hospitals, State Board of County Judges, State Bar of Wisconsin and the State Board of Health.

Postgraduate Education

To assist the non-psychiatric physician in assuming a greater role in the treatment of mental illness, the Division recommends the following:

1. That a pilot program of six weeks duration be undertaken in the fall of 1963 to provide postgraduate education in psychiatry for general practitioners. There would be a twenty-five dollar registration charge and the meetings would be held either from 2:00 to 4:00 p.m. or 8:00 to 10:00 p.m., one day a week, for six weeks. Sponsorship would be through the Division on Nervous and Mental Diseases with cooperation from the University of Wisconsin Department of Psychiatry, Wisconsin Psychiatric Institute, Mental Hygiene Division of the Department of Public Welfare, the State Board of Health and the Wisconsin Academy of General Practice. The pilot program could be presented on a budget of $1,000.00. Any expenses over and above the registration fees would be met by supporting organizations. On the basis of the pilot program the Wisconsin Psychiatric Institute would make a formal application for a long-term, sizable grant of $30,000.00 or more for a statewide program of meetings. The grant would be sought from the National Institute of Mental Health. It is recommended, however, that the State Medical Society's Division on Nervous and Mental Diseases be the coordinating agency to initiate the pilot program.
2. It is further recommended that the Division collaborate with the Society's Commission on Scientific Medicine in developing and promoting a teaching program at Central Colony to better acquaint physicians with facilities and proposed out-patient diagnostic services.
3. It is further recommended that a series of one day teaching programs be developed for physicians on "the mildly retarded child." These would be held in the same fashion as the circuit teaching programs and would stress how the physician can assist the parents with a mildly retarded child. These programs would be sponsored by the Division on Nervous and Mental Diseases through the Charitable, Educational and Scientific Foundation of the State Medical Society with the same agencies as listed in (1) above assisting in the financing and publicity plus the Bureau of Handicapped Children.
4. It is further suggested that psychiatry for general practitioners be included as part of a series of one day meetings to be held at the State Medical Society Headquarters once each month starting in the fall of 1963. Several subjects will be covered in each of these one day sessions and it is felt that psychiatry should be part of these programs along with surgery, pediatrics, obstetrics and other specialty fields.

It is the feeling of the Division that this ambitious program of postgraduate education in the field of psychiatry is urgently needed and should be implemented just as rapidly as possible.

Revision of Commitment Laws

The Division, through a subcommittee, has initiated a study of the commitment laws of the state. An initial meeting with representatives of medical, legal and sociologic interests on September 29, 1962 considered institution of proper mechanisms for the release from custody of those adjudged insane. This exploratory meeting resulted in recommendations that a smaller committee be formed to consider what legislation is necessary in this area. It is anticipated that the conclusions of this committee will be submitted to the House of Delegates in May of 1964.

Legislation

The Division has analyzed a large number of bills relating to mental health which are currently before the Wisconsin Legislature. Its advice has been provided to the Commission on Public Policy to assist it in planning legislative action. Among these recommendations is a firm and strong stand of opposition to the passage of Bill 77, S. related to the certifica-

tion of psychologists. The matter of relationships between medicine and psychology will continue to receive attention from the Division.

DIVISION ON NERVOUS AND MENTAL DISEASES
Keith M. Keane, M.D., Appleton, Chrm.
Charles A. Wunsch, M.D., Green Bay, Vice Chrm.
Otto A. Dittmer, M.D., Ripon
Raymond Headlee, M.D., Milwaukee
Francis M. Forster, M.D., Madison
Walter J. Urben, M.D., Madison
Henry Veit, M.D., Milwaukee
Edward E. Houfek, M.D., Sheboygan
J. T. Petersik, M.D., Oshkosh
G B. Tybring, M.D., Madison
Jean P. Davis, M.D., Milwaukee
A. A. Lorenz, M.D., Eau Claire
T. J. Nereim, M.D., Madison

■ REPORT OF THE DIVISION ON SCHOOL HEALTH—1962–1963

L. M. Simonson, M.D., Sheboygan, Chairman

Health Appraisals

The Division re-emphasizes its view that under an ideal of attainment each parent would assume his responsibility for continuous and frequent examinations of his children from birth to maturity. However, Division activities continue to include encouragement of programs which insure that all children will be given the benefit of health examinations, while working toward the ideal goal of acceptance of full responsibility by parents. Activities during the past year include:

a. A conference during the Wisconsin Work Week of Health in which the roles of the parent, physician, educator and public health officials were discussed, with emphasis on making the health appraisal a learning experience.
b. The booklet "School Health Examinations," published by the Division as a guide for physicians and school authorities, is being revised to present the most current policies and incorporate a simplification of the health examination record.
c. Plans are underway for Division participation in a series of regional conferences sponsored by the Department of Public Instruction for introduction of the second phase of the President's Youth Fitness Program, which will emphasize health appraisals.

Physician-Educator Cooperation

Numerous examples of good school health programs in Wisconsin communities, brought about by close cooperation of physicians and educators, have come to the attention of the Division. These serve as examples for other communities where closer liaison would result in more effective programs. Under Division initiative, the President of the State Medical Society and the Superintendent of Public Instruction urged school administrators and county medical society representatives to establish such liaison and bring about a permanent organization for continued cooperation in the area of school health. The communication has resulted in initiation of such liaison in some communities, and will be the basis of continued efforts by the Division to accomplish that end.

Because of the importance of the health appraisal, physicians are urged to make it a worth while learning experience, as well as a fact-finding procedure, for the child, parent and teacher.

Medical Aspects of Sports

Prevention of athletic injuries and care of the injured participant continue to be a major concern of the Division. In August, 1962, the Division presented two programs on these subjects during the Summer Coaches Clinics of the Wisconsin Interscholastic Athletic Association. It has cooperated with the Commission on Scientific Medicine in presentation of a series of such programs during the Annual Meeting, and encourages individual physicians to attend the program scheduled this year on Thursday, May 9.

Of significance to practicing physicians are the 1962 changes in the Wisconsin Interscholastic Athletic Association's "days out" regulations, made in consultation with the Division, to rely to a much greater extent on the attending physician's judgment in determining how long a participant must remain out of competition following an injury.

Health Education

In an effort to further improve teacher competency in health education, the Division initiated a letter to the presidents of all colleges and universities in the state urging more health instruction for all future teachers, and particularly those preparing for health education.

A significant aid to teachers in health education is anticipated from a research project financed by a grant of $2,500 from the State Medical Society through its Charitable, Educational and Scientific Foundation. The research involves screening of health education materials and will result in the publication of a guide for use by classroom teachers.

DIVISION ON SCHOOL HEALTH
L. M. Simonson, M.D., Sheboygan, Chrm.
William T. Brodhead, M.D., Madison
Frances A. Cline, M.D., Rhinelander
E. E. Bertolaet, M.D., West Allis
James C. H. Russell, M.D., Fort Atkinson
Horace K. Tenney, III, M.D., Madison
F. W. Reichardt, M.D., Stevens Point

■ REPORT OF THE DIVISION ON VISUAL AND HEARING DEFECTS—1962–1963

Meyer S. Fox, M.D., Milwaukee, Chairman

During the past year the Division on Visual and Hearing Defects operated as two Subcommittees: 1) The Subcommittee on Visual Problems with Dr. John Hitz as Chairman, and 2) The Subcommittee on Ear, Nose and Throat Problems with Dr. Meyer S. Fox as Chairman.

The Division continued to cooperate and assist in school hearing testing programs through the Division on Handicapped Children. Also, the Division has given advice in industrial hearing programs when called upon. Our Division has been alerted to and is keeping close watch regarding the attempt on the part of non-medical personnel to gain recognition and permission to participate in hearing testing screening programs in schools and industry. The Division members strongly feel that the detection, diagnosis, prevention and treatment of hearing impairments, regardless of cause or causes, are primarily medical functions and responsibilities and shoud not be undertaken or performed without medical supervision. A recommendation was made that the State Medical Society of Wisconsin sponsor a one or two day instruction course for the training of audiometric technicians who will perform hearing testing programs in industry under medical supervision. It was suggested that such courses be arranged through the University of Wisconsin at Madison, University of Wisconsin at Milwaukee or Marquette University. It was further suggested that these training courses be sponsored in cooperation with the Wisconsin State Industrial Commission. Two recent legislative bills were considered by the Subcommittee on Visual Problems. Bill 134, A. was of particular concern to the ophthalmologists, inasmuch as this bill would permit optometrists to obtain by legislative action the right to evaluate in-

dustrial accidents and diseases of the eyes on a par with physicians and also to recognize the testimony of optometrists in compensation and court proceedings. Members of the Division joined in the efforts by the State Medical Society to oppose this bill at public hearings in the Legislature.

During the past year S. B. Russell, M.D., member of the Division on Visual and Hearing Defects for many years, died and Watson B. Larkin, M.D., Marshfield, was appointed to complete his unexpired term.

DIVISION ON VISUAL AND HEARING DEFECTS

Meyer S. Fox, M.D., Milwaukee, Chrm.
George Nadeau, M.D., Green Bay
C. G. Reznichek, M.D., Madison
W. B. Larkin, M.D., Marshfield
Richard J. Fogle, M.D., Racine
James V. Bolger, Jr., M.D., Waukesha
John B. Hitz, M.D., Milwaukee
Donald A. Peterson, M.D., Madison
Richard H. Brodhead, M.D., Wausau

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—It reviewed the reports of the six divisions with much interest and noted that all were quite active and recommended support for their several programs. It further recommended to all 10 divisions of the Commission on State Departments that the chairman or his designee appear before the appropriate reference committee so that the Society as a whole might obtain a greater understanding of their programs. It particularly urged medical societies to utilize the facilities of the tuberculin and hypertension screening units. It recommended that the Division on Nervous and Mental Diseases investigate and explore with the State Department of Public Welfare the functions of the guidance and mental health clinics established throughout the state so that their aims and purposes might be more clearly defined and utilized. The committee felt that county medical societies should be stimulated to take a greater interest in the operation of these guidance centers.

HOUSE OF DELEGATES ACTION—Adopted the reports of the six divisions of the Commission on State Departments as recommended by the Reference Committee.

■ REPORT OF THE COMMISSION ON SCIENTIFIC MEDICINE—1962–1963

R. W. Farnsworth, M.D., Janesville, Chairman

Scientific teaching programs this past year have emphasized certain large subjects. Four programs (Sheboygan, Wausau, Eau Claire and Janesville) have been held on the subject of "Strokes"; five programs (Dodgeville, Rhinelander, Rice Lake, Racine, and Oshkosh) have been held on the subject of "Clinical Electrocardiography"; and two Maternal Mortality Institutes have been held in Kenosha and Green Bay. In addition to these, a two-day "circuit" on surgery, internal medicine, and pediatrics was held in Green Bay and Antigo. Tentative plans are being made for several programs in the area of mental health, and in cooperation with the Division on Maternal and Child Welfare a "test" program on "The Sick Child in the Hospital" may be presented in the north this coming summer.

The programs noted above have enjoyed a combined attendance of 540 persons, including 448 doctors and the balance hospital personnel.

In addition to these special teaching programs the Society, through the agency of the Charitable, Educational and Scientific Foundation, has furnished 62 scientific programs to 28 county societies and 2 councilor districts, with a combined attendance of 1770 physicians.

The major effort of the Commission has been the development of the Annual Meeting program, and this year special attention has been directed to the 50th Anniversary of the founding of Marquette University School of Medicine. Distinguished alumni who are now engaged in teaching have been invited back for lectures associated with the Annual Meeting program.

While many state medical meetings are reported to be in serious decline, the Annual Meeting in Wisconsin remains strong and representative of the entire profession. This has been achieved by the close working relationship established with all specialty societies and the Wisconsin Academy of General Practice. All groups within the structure of the State Medical Society have been most cooperative, and the Annual Meeting continues to provide a program which enjoys a high level of professional instruction.

As will be noted by reviewing the Annual Meeting program, this year's meeting directs special attention to "The Medical Care of the Aged." It is anticipated that subsequent annual meetings will devote the entire first day to a broad basic subject, which will be of interest to a large number of physicians.

Few states compare to Wisconsin in the extent of postgraduate medical education offered members. A recent review of past experience from 1940 through 1962 shows that a total of 250 special teaching programs, other than the Annual Meeting, have been presented for the benefit of Society members. These programs have been varied, and are broken down as follows:

Circuit Teaching Programs	164
Industrial Health Clinics	29
Cancer Clinics	22
Maternal Mortality Institutes	14
Care of the Newborn Conferences	2
Prematurity Institutes	13
Mental Retardation Conferences	2
Oxygen Therapy Institutes	3

It is the opinion of the Commission on Scientific Medicine that Wisconsin is serving its members by way of postgraduate instruction far above the average. The Society has recognized that postgraduate medical education must continue to be the central core of the State Society's effort. While the over-all program has been largely supported by funds from state agencies, voluntary health agencies, and miscellaneous support, the Council and the House of Delegates have never hesitated to provide funds when such funds for postgraduate teaching have been requested.

The Commission recognizes a special responsibility to the physician member who does not devote his time to a single specialty. His many facets of medical practice require that he avail himself of all the new knowledge of medical science which can be brought to him. Because of the demands of his practice he is unable to leave his community and his patients to the extent of many physicians engaged in specialty practice. For that reason the Commission has attempted to concentrate its educational efforts to fit the needs of the generalists. Working cooperatively with the Wisconsin Academy of General Practice, we are able to offer special teaching programs in areas not served by programs sponsored directly by the Academy.

The Commission on Scientific Medicine is anxious to have a degree of flexibility applied to teaching programs. While the traditional "Circuit Teaching Programs" have been reduced in number, more attention has been directed to specialized subjects, and it is hoped that by working with the Academy and the various specialty groups within the structure of the State Society, we can plan a combination of centralized teaching programs, utilizing the splendid facilities of the State Society headquarters in Madison, and other programs which will be presented in areas of the state removed from the teaching centers in Madison and Milwaukee.

The Commission wishes to express its appreciation to the Council and the House of Delegates for the continued support and encouragement given in respect to teaching programs.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—It commended the Commission for its series of fine programs of postgraduate education. The committee noted that the attendance at these meetings was not as good as expected from the quality of the programs and the effort put forth, and it encouraged greater attendance by the practicing physicians of Wisconsin. It further suggested that a continued effort be made by the Commission to explore all methods of mass communication to bring widespread interest into the immediate locale of the practicing physician by use of taping, closed television and telephone circuit. It recommended acceptance of this report.

HOUSE OF DELEGATES ACTION—Accepted the report of the Commission on Scientific Medicine as recommended by the Reference Committee.

■ REPORT OF THE COMMITTEE ON DISASTER MEDICAL CARE—1962–1963

J. S. Wier, M.D., Fond du Lac, Chairman

Medical Self-Help Training

Major emphasis in the past twelve months in disaster medical care has been on the medical self-help training program, designed to train the public to meet their own medical needs in case of national disaster. The Committee on Disaster Medical Care serves in an advisory capacity to the State Board of Health in the program, and the chairman is a member of the statewide planning group.

The Committee on Disaster Medical Care played a major role in development of a pilot training program in Wisconsin. With 80 kits, a total of 1,046 students were trained between March 1 and December 31, 1962. Individual committee members served as instructors of courses in their own communities, including one for employees of the State Medical Society. The pilot program revealed that the course, with some changes, could be expanded to a general statewide program. That program is now under way, with 243 kits distributed by the end of February and a total of 800 expected to be in use in the state by mid-year. Eventual goal is to train one member of each family in the state in medical self-help.

While it is desirable that the course be taught by persons with a medical background, the pilot program has revealed that this is not a necessity. However, the success of the program depends on the medical direction provided at the local level.

The Committee *recommends that the House of Delegates urge County Medical Societies and individual physicians to provide professional leadership for medical self-help training programs within their own communities and be available as sponsors and instructors on an advisory basis for the conduct of individual courses.*

200 Bed Emergency Hospitals

A significant achievement in Wisconsin civil defense organization in 1962 was the completion of a five-year program to orient staffs of 200 bed emergency hospitals positioned in 56 communities in the state. In the five years 242 sessions were held for 8,043 staff members. The State Board of Health, which assumed major responsibility in this orientation program, and county medical directors for civil defense are to be commended for this successful program to insure that the emergency hospitals will be utilized with greatest efficiency in case of disaster.

Conclusion

Public interest in civil defense activities fluctuates with the international situation; however the planning of civil defense health services requires constant effort by individual physicians in their own communities. The Committee feels that effective leadership is being provided on the state level by the Bureau of Civil Defense and State Board of Health, and is gratified by the accomplishments in a number of communities. However, there are still those areas which are without county civil defense medical directors, chiefs of staff for emergency hospitals, and other key medical personnel. It is to the filling of these vital vacancies that the efforts of the medical profession must be directed.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—It supported the Committee's recommendation that the House of Delegates urge county medical societies and individual physicians to provide professional leadership for medical self-help training programs within their own communities and be available as sponsors and instructors on an advisory basis for the conduct of individual courses. It further recommended that efforts be made by the medical profession to help communities fill such vital vacancies as civil defense medical directors, chiefs of staff for emergency hospitals, and other key medical personnel. It recommended adoption of this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Disaster Medical Care as recommended by the Reference Committee.

■ INTRODUCTION OF RESOLUTIONS

D. M. Willson, M.D., Milwaukee

As the Councilor for District 12, I would like to introduce five resolutions. These are resolutions 8 through 12. They have all been mimeographed and are available for you. The only reason for this is the difficulty that the delegates have in adhering to the thirty-day rule in getting resolutions in.

Since this rule does not apply to a constitutional officer, I have this privilege, and so exert it.

SPEAKER CALLAN: The Chair would like to call attention to the fact that there are now two resolutions number 8 and two resolutions number 9. So, with your permission, Resolution number 8 and Resolution number 9, just presented, will be Resolutions numbers 13 and 14, respectively.

RESOLUTION NO. 10

Introduced by: Milwaukee County Medical Society

WHEREAS, the Council on Medical Education and Hospitals of the American Medical Association has been unable to recommend to the House of Delegates an effective and equitable plan of integration of the medical internship into the spectrum of medical education and hospital operation, and

WHEREAS, the education value of the medical internship has been open to serious question and much difference of opinion among physicians interested in medical education, and

WHEREAS, the Council on Medical Education and Hospitals has permitted a substantial discrepancy to develop between the number of approved internships and the number of available interns, and

WHEREAS, most physicians in private medical practice consider the methods now employed by the Council on Medical Education and Hospitals to reduce this discrepancy as alien to the best interests of the graduate medical student, the public, and the American Medical Association, now therefore, be it

Resolved that the State Medical Society of Wisconsin through its representatives in the House of Delegates urge the American Medical Association to direct the Council on Medical Education and Hospitals to continue approval of all internships which were approved on July 1, 1962, until the

Millas report is submitted and implemented by the American Medical Association, and be it further

Resolved that the House of Delegates establish immediately an appeal mechanism whereby decisions of the Council relative to internship approval (or disapproval, or other status) may be reviewed.

RESOLUTION NO. 11

Introduced by: Milwaukee County Medical Society

WHEREAS, the management survey report of the State and County Medical Societies in Wisconsin prepared by the firm of Booz, Allen and Hamilton and Associates, requires thorough study and evaluation, and

WHEREAS, such study and evaluation, because of the great length and scope of the report will require considerable time and effort, now therefore, be it

Resolved that the speaker of the House of Delegates be directed to appoint an ad hoc committee to conduct such a study and evaluation and to make recommendations for appropriate implementation; and be it further

Resolved that this ad hoc committee be composed of nine members named at large from the State Medical Society, three of whom shall be members of the Medical Society of Milwaukee County. And be it further

Resolved that this committee shall make a final report to the next meeting of the House of Delegates, and be it further

Resolved that the balance of the special assessment levied for the management survey remaining above and beyond $40,000 payment made to Booz, Allen & Hamilton, as well as the cost of reproduction of duplicate surveys, be available to provide an adequate staff for such a committee, and be it further

Resolved that no officer, or staff member or former staff member of the State, or County Medical Society, or an employee or former employee thereof shall be eligible for employment on the staff of the committee.

RESOLUTION NO. 12

Introduced by: Milwaukee County Medical Society

WHEREAS, the Wisconsin State Medical Society meets but once a year, and

WHEREAS, the meeting is one of educational value and also acts as a meeting ground for liaison between doctors throughout the state, and

WHEREAS, the meeting is one at which certain citations and honors are bestowed upon members of our profession, and

WHEREAS, the annual dinner is the climax of this meeting, now therefore, be it

Resolved that no social or scientific meetings be scheduled by any organized groups within the organization to compete with attendance at the Annual Dinner of the State Medical Society.

RESOLUTION NO. 13

Introduced by: Milwaukee County Medical Society

WHEREAS, the personnel of the Council on Medical Education and Hospitals of the American Medical Association has consisted predominantly of physicians engaged full time in medical education, and

WHEREAS, the Council thus constituted has developed and implemented policies which are insensitive to the educational potential, interest and requirements of privately practicing physicians and private community hospitals, and

WHEREAS, many physicians in private practice, and working in private community hospitals are also actively engaged in medical education at all levels and have a broader understanding, not only of the education needs of medical students and physicians in training, but also of the needs of the entire medical profession and the general public, now therefore be it

Resolved, that the State Medical Society of Wisconsin through its delegates to the American Medical Association, urge the House of Delegates to take appropriate measures to require that 75% of the personnel of the Council on Medical Education and Hospitals be physicians engaged principally in private medical practice and that such requirements become implemented at the time of the 1963 Clinical Meeting of the American Medical Association.

RESOLUTION NO. 14

Introduced by: Milwaukee County Medical Society

WHEREAS, it is in the best interest of the medical student, the intern and physicians individually and collectively, as well as the general public, that private community hospitals, whenever possible, function in the stimulating environment of a medical teaching program, and

WHEREAS, the excess of approved internships over the number of available interns has made the maintainance of an approved internship in private community hospitals increasingly difficult, and

WHEREAS, it is highly desirable, if not essential, that at least part of the clinical experience of medical students and doctors in training be derived from the care of private patients, and

WHEREAS, current trends show unquestionably that a large and increasing percentage of the training of medical students, interns and residents is received in public and medical school affiliated hospitals with predominantly charity patient population, now therefore be it

Resolved that the State Medical Society of Wisconsin, through its representatives in the House of Delegates of the American Medical Association, urge the American Medical Association to attempt to relieve this deficiency in medical education by instituting a trial program of three to five years duration permitting internship training only in private community hospitals with approved internship programs.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Resolution Nos. 10, 13 and 14, introduced by the Milwaukee County Medical Society, were considered together because of their similarity of intent. The Committee recommended that these resolutions not be accepted because they were ambiguous, but the Committee pointed out that they did reflect generally the concern of the medical profession in the future internship training program in private hospitals. It urged the delegates to the AMA to express this concern at the June meeting of the American Medical Association.

HOUSE OF DELEGATES ACTION—Adopted the recommendations of the Reference Committee.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—The Committee considered Resolution No. 11, but declared it out of order.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Reference Committee.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—The Committee concurred with the suggestion contained in Resolution No. 12 and recommended its acceptance.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Reference Committee.

RESOLUTION OPPOSING FEDERAL REGULATIONS OF ANIMALS IN RESEARCH

Introduced by: R. E. Galasinski, M.D., Milwaukee

WHEREAS, The Wisconsin State Medical Society is an organization devoted to the advancement of medicine; and

WHEREAS, Proposed legislation is now before the Congress of the United States to limit, license, and police scientific research requiring a study of animals, these bills being known as the Clark–Neuberger Bill (S 533), the Ashley Bill (HR 4620), the Ashley Bill (HR 5430), and the Randall Bill (HR 4856); and

WHEREAS, The ostensible purpose of these bills is to assure humane treatment of laboratory animals; and

WHEREAS, These bills make no provision for training in laboratory animal care, and no provision for information interchange on laboratory animal medicine, and no provision for better facilities for laboratory animal care; and

WHEREAS, These restrictive bills pose a distinct and serious threat to the conduct of humane studies of laboratory animals; and

WHEREAS, These bills are promoted by persons long prominent in efforts to sabotage medical research involving animals; and

WHEREAS, The passage of these bills would lead to the introduction of even more oppressive legislative acts; now, therefore, be it

Resolved, By the Wisconsin State Medical Society meeting in Milwaukee, Wisconsin, May 6, 7, and 8, that S 533, HR 4620, HR 5430, HR 4856, and other restrictive legislation to scientific investigation be sighted as insincere proposals aimed not at promoting humane treatment of animals but rather at the incumbrance of scientific research. Furthermore be it

Resolved, That the Wisconsin State Medical Society urge the Congress of the United States to support the advancement of humane animal studies designed to promote the welfare of laboratory research animals without obstructing scientific medical research. Again further be it

Resolved, That our secretary be directed to send a copy of this resolution to each of the Senators and Representatives from Wisconsin and to the Subcommittees in the House and Senate to which this legislation is assigned.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—It recommended adoption of the resolution opposing federal regulation of animals in research.

HOUSE OF DELEGATES ACTION—Adopted the resolution as recommended by the Reference Committee.

■ REMARKS OF THE PRESIDENT OF THE WOMAN'S AUXILIARY TO THE STATE MEDICAL SOCIETY—1962–1963

Mrs. E. M. Dessloch, Prairie du Chien

This has been a wonderful and rewarding year for me. It has been a tremendous opportunity for which I am truly grateful. I have met many outstanding people and formed new friendships. It has been a great joy to work with these dedicated women. My gratitude goes to the County Auxiliaries, who invited me to visit and gave me such a warm and gracious welcome.

In my travels throughout the state, and also the out-of-state conventions and meetings that I attended, one fact became very evident, the willingness, interest and desire to serve shown by the members of all of the medical auxiliaries. The steady growth of the auxiliaries and their accomplishments indicate the physician's wife's acceptance of her role in her community and her wish to be of service.

They who have the spirit and determination to do things well, those who know that nothing is accomplished without hard work and sacrifice, and those who are willing to share responsibilities and work with each other, accomplish many things.

The time has come to evaluate my activities. We have thirty-four organized auxiliaries in the state, and 1,800 members. I have especially emphasized AMA-ERF, community service, and the Museum of Medical Progress, located in Prairie du Chien. It is wonderful to observe how well the doctors' wives cooperate and work with all types of community service. Such interest is shown in contributing money to AMA-ERF. The Museum of Medical Progress has been a source of increasing interest, not only to the people in our own state, but also for many of the neighboring states. The continuing story of medical progress must be told, not only to improve the health of these people, but to preserve the "health" of the medical profession. Slides of the Museum were shown in many county auxiliaries.

I would like to express my sincere appreciation to Mr. Crownhart and his staff for the wonderful cooperation and help given in all auxiliary activities. A very special thank you to the secretary of the Medical Auxiliary, Leona Chesemore. Her keen knowledge of the work of the Medical Auxiliary makes our task much lighter. She, too, is always very willing to serve.

In summarizing the year's work, I would like to quote Edward Hale:

"I am only one. But I am one,
I can't do everything. But I can do something.
That which I can do, I ought to do,
And by the Grace of God, I tried to do my best."

My sincere and grateful appreciation for the privilege of serving as President of the Woman's Auxiliary to the State Medical Society of Wisconsin.

■ REMARKS OF A.M.A. DELEGATE

R. E. Galasinski, M.D., Milwaukee

At the AMA meeting in Los Angeles last November, Doctor McKittrick, Chairman of the Council on Medical Education and Hospitals, introduced and presented a report on the Intern and Resident. This was introduced primarily for information, but it had some very potent recommendations. It was introduced with the thought that this be brought back to the various states where it would be discussed and finally decided upon at the next House of Delegates' session in June of this year.

Apparently, after this report was submitted, they realized that the subject of prepaid insurance which would be involved, had some very significant impacts on how such a plan could operate.

As a consequence at the AMA level, then the Council on Medical Services met with the Council on Medical Education and Hospitals, and the two Councils are now submitting to the House of Delegates, a redraft of the Report on the Compensation of Interns and Residents.

COMPENSATION OF HOUSE OFFICERS

This special report is submitted by the Council on Medical Service and the Council on Medical Education and Hospitals in response to instructions of the House of Delegates in June, 1961. It is based on the considerations and conclusions of the Liaison Committee of the two Councils.

Part I. Introduction:

The action of the House in June of 1961 was in response to the report of the Special Study Committee of the Council on Medical Education and Hospitals charged with consideration of the general problems of facilities for medical education and recruitment to medicine. The House, in adopting the report of the Special Study Committee, acknowledged that "the financially lean years of the internship and residency . . . a part of the costly medical education complex from the viewpoint of students . . . is known to have a deterring influence on preprofessional students who favor a career in medicine but are financially insecure;" and, to lessen this economic pressure on medical students the House recommended that:

"1. The graduate physician serving as intern or resident should receive financial support commensurate with his professional responsibilities and with due recognition of his educational opportunities, and that,

"2. The medical profession must assume an increasing responsibility for the development of appropriate methods of financial support of the intern and resident, so as to accomplish the above objective."

The specific purpose to be served by the present report is contained in the action of the House of Delegates (Report of the Reference Committee on Medical Education and Hospitals, June, 1961) as follows:

"It is urged that the Council on Medical Education and Hospitals and the Council on Medical Service continue their joint study of the best mechanisms by which these recommendations may be accomplished."

Part II. Conclusions and Recommendations:

A. The Council on Medical Service and the Council on Medical Education and Hospitals are in complete agreement with the June, 1961 policy statement of the House of Delegates that, "The graduate physician serving as intern or resident should receive financial support commensurate with his professional responsibilities and with due recognition of his educational opportunities."

B. The Councils are also in complete agreement with the corollary policy statement of the House of Delegates that "the medical profession must assume an increasing responsibility for the development of appropriate methods of financial support of the intern and resident, so as to accomplish the above objective."

C. Since the majority of house officer training programs depend to a variable degree upon the participation of paying patients, the Councils conclude that fees from all sources attributable to services provided by house officers to such patients should be collected for and allocated solely to the financial support of the graduate training programs. The following principles having direct application to this conclusion were established as American Medical Association policy in 1961:

"Each doctor engaged in the care of the patient is entitled to compensation commensurate with the value of the services he has personally rendered."

"No doctor should bill or be paid for a service which he does not perform. . ."[1]

D. While the term "house officer" embraces both the intern and the resident, the Councils believe that the educational function of the initial year of hospital experience is of primary and paramount importance. The intern, certainly during his first year of hospital experience, properly assumes fewer significant professional responsibilities than does the resident at more advanced levels of competence, especially for definitive medical care or for major surgical procedures; accordingly, the recommendations in this report apply more generally to residents than to interns.

E. In specific response to the instructions of the Reference Committee, the Councils recommend the following principles to govern the assignment of professional responsibility of house officers for patients and the disposition of funds resulting from this relationship:

1. Assignment of responsibility to house officers for the care of patients shall be based on their competence to assume this responsibility.
2. The number of patients assigned to house officers shall be limited by the educational needs of the training program.
3. The care of such patients shall continue to be under the supervision of the attending staff physician, and ultimate responsibility for their care shall remain in his hands.
4. Paying patients shall be assigned to the house staff by the attending physician only with the knowledge and consent of the patients concerned.
5. A special fund of the professional staff should be established for support of house officer training programs, so that funds could be received from a variety of sources such as endowment income, grants, assessments, donations, fund-raising activities, hospital income from patients, and fees for professional care of patients.
   a. When the house staff has an assigned role in the professional care of paying patients, all applicable fees shall be collected and shall be deposited in the special fund.
   b. The special fund shall be administered by a committee of the attending staff.
   c. The fund shall be used exclusively in support of the house officer training programs, including the provision of adequate compensation for house officers.
   d. The fund shall not be used for support of the general operations of a hospital, medical school, university, or welfare department.

F. IT IS THE CONSENSUS OF THE TWO COUNCILS THAT THE SOURCES AND AMOUNT OF COMPENSATION FOR HOUSE OFFICERS, AS WELL AS THE APPORTIONMENT OF FINANCIAL RESPONSIBILITY, SHOULD BE DETERMINED LOCALLY BY AGREEMENT BETWEEN THE HOSPITAL GOVERNING BODY AND THE ATTENDING STAFF AND IMPLEMENTED IN ACCORDANCE WITH STATE LAWS AND THE ETHICAL PRINCIPLES OF THE AMERICAN MEDICAL ASSOCIATION.

APPENDIX A
to the
REPORT ON COMPENSATION OF HOUSE OFFICERS

Supporting Data and Discussion:

The level of compensation for house officers, if it is to be effective in recruitment of physicians, should take into account the cost in time and money of modern living and modern education, as well as a comparison of the remuneration of individuals of similar educational achievement in other professional fields. The following table shows comparative compensation for medical students and other graduate students in arts and sciences both before graduating with receipt of the professional degrees, as well as during subsequent training as house officers (MD), and as post-doctoral trainees (PhD).

Comparative Compensation for Medical and Other Graduate Students

Category of Student	Average Annual Earned Income	Source of Data
Medical Students	$500	AAMC Studies, 1959
Arts & Sciences Students	$2,000	Whiting, et al, Journal of Medical Education July, 1961.
Post-Doctoral Trainee	**Average Annual Starting Salary**	**Source of Data**
Intern (MD)	$2,800	Council on Medical Education & Hospitals, Annual Report, JAMA, November 17, 1962.
Resident (MD)	$3,300	
Arts & Sciences Trainees (PhD)	Post-Doctoral Research Fellowships, Air Force Office of Scientific Research $7,500–$9,300 Resident Research Associateships, National Aeronautics & Space Administration $9,500–$10,000	Research and Training Programs administered by the National Academy of Sciences—National Research Council, 1963–1964.

[1] Report of Reference Committee on Insurance and Medical Service, Proceedings of the House of Delegates, June 25–30, 1961, p. 157.

Traditionally, house officers have had responsibility primarily for the care of non-paying patients, in return for which they received board, room, laundry, and a stipend regarded usually as an educational allowance.

New factors presently influence this traditional arrangement:

First, most house officers are now married. This situation makes the board and room provisions less valuable because of the house officer's need to establish another household outside the hospital.

Second, an increasing number of patients whom the house officer serves are paying patients.

While the house officer undertakes graduate training primarily for educational purposes, it is nevertheless true that the level of professional responsibilities which he discharges in the care of his assigned patients often bears little relation to the level of his compensation. This may account, in part, for the widely varying patterns and practices throughout the country for the compensation of house officers.

An objective reappraisal of the true value of house officer services is a responsibility which must be accepted by the medical staff of each hospital.

To provide factual background information on the costs and sources of financing graduate training programs, a questionnaire study was made by the Council on Medical Education and Hospitals in August of 1960. This study showed that house officer training programs were supported from a variety of sources. These sources included *general hospital revenue, assessments* levied on the attending staff, voluntary *donations* by the attending staff, special *fund-raising activities* by others, income from *endowments* or *grants*, and income from third-party *medical care plans*. Of particular interest was the fact that in 20% of 818 non-federal hospitals responding to the questionnaire, special mechanisms had already been established for the collection of fees for the services of house officers to paying patients and for placing these fees in a special fund for support of the training programs, including compensation for the house officers.

Concern for adequate compensation of the house officer must be shared by the patient, the community, the hospital governing body, and the hospital attending staff, since each benefits from house officer services.

The *patient* benefits because he has professional care available in the hospital around-the-clock. The *community* itself benefits from the presence of competent professional services available at the hospital at all times for the care of all patients. Basic professional staff services in the hospital are available in the event of local or national emergency or catastrophe, and for the care of the community's indigent sick. The *hospital* benefits because it is the area within which these readily available professional medical services are provided for non-paying patients, and also because the house officer provides administrative and teaching services in connection with other hospital activities and training programs. With the modern conversion of the hospital population used for teaching from predominantly indigent to predominantly paying patients, the hospital *attending staff* benefits because the house officer provides a professional service to the attending physician in assisting him in the care of paying patients.

The Council on Medical Service and the Council on Medical Education and Hospitals agree that *a specific minimum salary level cannot be set for nationwide application in all hospitals*. Nevertheless, they believe that remuneration in all hospitals should be sufficient to support beginning house officers without resorting to outside employment. Cost-of-living estimates are generally available for most areas of this nation and could be used as guides by individual hospital staffs. As house officers progress through their training, the increases in their professional responsibilities should be recognized through annual increments in compensation.

The Councils believe *it is inappropriate to recommend a single method of improving compensation for uniform application throughout the country* because of the wide differences in (a) hospital organization and hospital sponsorship, (b) methods of hospital and medical care financing, and (c) types of practice and staffing in the many different institutions in the United States.

The methods for improving compensation of house officers *must be developed locally* through the mutual efforts of the hospital attending staff and the hospital governing body.

In some instances, hospital attending staffs have formed partnerships for purposes of compensating house officers as employees of the partnerships. The two Councils have been advised that such procedure is ethical and legal and that house officers compensated under this arrangement need not be licensed unless particular state laws specify otherwise. Regardless of the method by which the hospital attending staff participates in the compensation of the house staff, the hospital corporate body should not be relieved of responsibility for paying its share of such compensation through a mutually acceptable arrangement.

The hospital governing body is responsible for appointment of qualified physicians to the hospital attending staff upon recommendation of the appropriate staff committee. This same responsibility applies for appointment of qualified interns and residents to the hospital house staff. This responsibility of the hospital governing body would not be altered by changes in the methods of employment and levels of compensation of house officers. Nor would such changes alter in any way the operation of the training programs or the standards by which such programs are evaluated, approved, and listed by the Council on Medical Education and Hospitals in the Directory of Approved Internships and Residencies.

Now we, here, as delegates of the AMA, are introducing this so you may consider and direct us on how we should vote representing you.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—The Committee pointed out four problems for consideration: (1) the salary of the house staff, (2) the financing of the training program of the house staff, (3) techniques in collection of funds to support these programs, and (4) the unnecessary competitiveness that would be nurtured by the suggested method of recompense to the house staff. The Committee felt that the Society's AMA delegates are cognizant of these problems and should represent the State Medical Society accordingly. As submitted, the Committee felt the special report needed further interpretation and clarification by the national committees. It recommended acceptance of this report.

HOUSE OF DELEGATES ACTION—Accepted the report of the AMA delegate as recommended by the Reference Committee.

■ RESOLUTION NO. 1

Introduced by: La Crosse County Medical Society

WHEREAS, The State Medical Society of Wisconsin is composed of physicians from all parts of Wisconsin including those from the western half of the state, and

WHEREAS, The annual meeting of the State Medical Society has not been held at La Crosse or a city outside of Milwaukee for several years, and

WHEREAS, The State Medical Society did meet in La Crosse, Wisconsin at one time, and

WHEREAS, The city of La Crosse is easily accessible by means of automobile, airplane, and train, and

WHEREAS, The city of La Crosse has motel, hotel, and restaurant accommodations capable of handling a convention of three thousand people plus an auditorium which seats four thousand persons, and

WHEREAS, The physicians of La Crosse County are desirous of having the State Medical Society hold its annual meeting in the city of La Crosse, therefore be it

Resolved, That the La Crosse County Medical Society does invite the State Medical Society of Wisconsin to have its annual meeting in La Crosse, Wisconsin in 1964.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BY-LAWS—Although the Committee felt a note of thanks was in order to the La Crosse County Medical Society, it regretfully recommended Resolution No. 1 not be accepted at this time because of prior commitments.

HOUSE OF DELEGATES ACTION—Accepted the recommendation of the Reference Committee.

(Resolution No. 2 was withdrawn.)

■ RESOLUTION NO. 3

Introduced by: Dane County Medical Society, Board of Trustees

WHEREAS, In many counties of Wisconsin there are licensed physicians who are not members of the county or state medical societies; and

WHEREAS, On many occasions these non-member physicians utilize the facilities of their county medical society and of the State Medical Society of Wisconsin; now, therefore be it

Resolved, That these acceptable non-member physicians be expressly invited to join and participate in the activities of their county medical society and in the State Medical Society of Wisconsin; and be it further

Resolved, That participation in the activities of each county medical society and in the State Medical Society of Wisconsin be limited to members and invited guests who reside outside of the State of Wisconsin.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BY-LAWS—It recommended that Resolution No. 3 be passed as submitted by the Dane County Medical Society Board of Trustees, with the following changes in the last 'Resolved': "Resolved, That the participation of physicians in scientific programs of the State Medical Society of Wisconsin be limited to members and to invited guests who reside outside the state of Wisconsin."

HOUSE OF DELEGATES ACTION—Adopted the amendment as recommended by the Reference Committee and accepted Resolution No. 3 as amended.

■ RESOLUTION NO. 4

Introduced by: Brown County Medical Society

Resolved, That the members of the Brown County Medical Society wish a detailed annual financial statement including salaries and fees paid to any employee earning over $7,500 per year of the State Medical Society of Wisconsin, Wisconsin Physicians Service and any other services of the State Medical Society.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BY-LAWS—It recommended that Resolution No. 4, introduced by Brown County Medical Society, be accepted with the following revision "Resolved, That the delegates of the State Medical Society be furnished with a detailed annual financial statement, including a breakdown of salaries paid to any employee of the State Medical Society and its divisions, and fees paid to outside consultants."

HOUSE OF DELEGATES ACTION—Rejected the amendment recommended by the Reference Committee. Rejected the original resolution as submitted by Brown County Medical Society.

■ RESOLUTION NO. 5

Introduced by: Brown County Medical Society

Resolved, That the members of the State Medical Society of Wisconsin be encouraged to submit to a special page or column of the Wisconsin Medical Journal any item concerning which said member would like to know the sentiment of the members at large, whether this be approval or disapproval; and be it further

Resolved, That those items be arranged in tabular form and submitted to each member once every three months, within two weeks of the mailing date of the most recent issue of the Journal. The members will be requested to return the tabular form to the President of the Society with their vote expressed. The results of these polls will be published in the subsequent issue of the Journal. This information will then become valuable information in forming the basis of individual resolutions to be presented to the House of Delegates at the annual meeting.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BY-LAWS—It recommended rejection of Resolution No. 5 as introduced by Brown County Medical Society because of lack of a fiscal note, but it suggested that the editor of the *Wisconsin Medical Journal* take the suggestion under consideration.

HOUSE OF DELEGATES ACTION—Rejected Resolution No. 5 as recommended by the Reference Committee.

■ RESOLUTION NO. 6

Introduced by: Brown County Medical Society

WHEREAS, Resolution 16 was introduced to the House of Delegates of the American Medical Association in November, 1961, and

WHEREAS, Resolution 16 is stated as follows:

> We propose legislation by the Congress of the United States to this effect: that each person whose income is inadequate for the purchase of his own medical care may, upon his voluntary request, and with his eligibility automatically determined by his current income records, obtain assistance from the federal—(state and local) government for his own purchase of comprehensive prepayment doctoring in the open free, competitive market of care; and

WHEREAS, Resolution 16 was approved unanimously by the Oregon State Medical Society; therefore be it

Resolved, That the members of the Brown County Medical Society endorse resolution 16 as stated and that our delegates to the State Medical Society be instructed to urge that our representatives in the American Medical Association act favorably upon this resolution; and be it further

Resolved, That the Secretary of the Brown County Medical Society be instructed to publicize this resolution in the form of an article to be submitted to the Green Bay Press Gazette.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BY-LAWS—It recommended rejection of Resolution No. 6.

HOUSE OF DELEGATES ACTION—Rejected Resolution No. 6 as recommended by the Reference Committee.

■ RESOLUTION NO. 7

Introduced by: Section on Neurology and Psychiatry

WHEREAS, The specialties of Neurology and Psychiatry have progressively developed into such distinct and different areas of medicine; and

WHEREAS, It is difficult to voice and express these two disciplines as one; and

WHEREAS, The specialty of Psychiatry is dominantly represented in the Section on Neurology and Psychiatry; therefore be it

Resolved, That the Section on Neurology and Psychiatry be changed to "Section on Psychiatry."

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BY-LAWS—It recommended rejection of Resolution No. 7.

HOUSE OF DELEGATES ACTION—Rejected Resolution No. 7 as recommended by the Reference Committee.

Constitutional Amendments Introduced in May 1962 for action in May 1963

(Printed in the March and April 1963 issues of the Wisconsin Medical Journal)

Note: Material to be deleted is in parentheses; new material is in italic. The Constitution and Bylaws were published on pp. 57–64 of the January 1963 Blue Book issue of the *Wisconsin Medical Journal.*

Amend Article VI of the Constitution as follows:

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The (president, the) president-elect, the secretary, *and* the treasurer (and the speaker of the House of Delegates) shall be ex officio members of the Council, but without the right to vote, *and the president and speaker of the House of Delegates shall be ex officio members with such right to vote.* (Nine) *A majority* of its *voting* members shall constitute a quorum.

Amend Section 1 of Article IX of the Constitution by addition of the following paragraph:

No person shall hold more than one of such offices concurrently.

Amend the first paragraph of Section 2 of Article IX of the Constitution as follows:

The officers, except the councilors *and the speaker of the House of Delegates,* shall be elected annually. *The term of the speaker shall be for two years.* The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—It recommended adoption of the amendment to Article VI of the Constitution. It recommended adoption of the amendment to Section 1 of Article IX of the Constitution. It recommended adoption of the amendment to Section 2 of Article IX of the Constitution.

HOUSE OF DELEGATES ACTION—Accepted the recommendations of the Reference Committee.

STATEMENT BY THE COUNCIL ON THE DESIRABILITY OF TWO MEETINGS OF THE HOUSE OF DELEGATES A YEAR, THE FIRST SUCH YEAR TO BE 1963

The State Medical Society of Wisconsin, as we have been reminded from time to time in recent years, is no longer an organization which conducts its affairs by resolutions viewing with pride and pointing with alarm. Active liaison is maintained with every state department dealing with affairs of health, and these are many and complicated. The Society itself, in strictly medical activities, has a budget of approximately $400,000 annually, while the administrative budget for its Blue Shield plan exceeds $1,000,000. The Charitable, Educational and Scientific Foundation is now beginning to function as contemplated at the time of its creation. Its student loan fund, operated by direct loan and also through the mechanisms of the American Medical Association where that seems desirable, has aided many students; and virtually all scientific activities of the profession are now carried on through the Foundation supported by grants from the dues structure of the Medical Society and from organizations which have a special interest in aiding the profession in scientific activities. The operation of the Museum of Medical Progress and Stovall Hall of Health in Prairie du Chien is substantial and most effective.

The tradition of the House of Delegates of the Society has been about a three-hour initial session to organize the House, receive reports and resolutions, arrange for a nominating committee, and other miscellaneous matters. During the second day of the Annual Meeting, the reference committees are in session, and often have difficulty in completing their reports by the time the House is convened in the early evening. This session normally lasts two hours and, again normally, this concludes the business activities as such. The third session is devoted to the election of officers and reception of the new president-elect.

To expect 107 delegates, and their alternates, and interested members and officers of the county societies to digest the voluminous material which is circulated for one annual meeting of the House of Delegates is expecting too much.

In addition, every other year we expect our staff and committees to function actively at a time when they are confronted with the administrative pressures resulting from the Legislature being in session, and when a great deal of time must be given to the presentation of facts and opinions to that body.

Federal legislation in many respects commands the attention of all physicians, and the socio-economic activities of the Society are matters of prime, although not major, responsibility.

The Council therefore believes that in the foreseeable future at least, the House of Delegates should meet twice each year—once in May chiefly to conduct the traditional affairs of medicine, including the election of officers, and the second time in the fall, preferably in Madison and during October.

Anticipating approval of the House, the first such meeting will be held in the fall of 1963. The dates of October 18–19 have tentatively been reserved.

Fiscal Note: Because mailing of material would be divided between two sessions of the House, there would be some additional postage costs involved. The Presidents' Room at the State Medical Society would be used, avoiding outside meeting hall rental. There would be some food costs. Total expense: $1,500–$1,800.

Schedule

First day: (Friday)

2:00 p.m.	Registration of Delegates
3:00 p.m.	Call to Order
5:00 p.m.	Recess
6:00 p.m.	Buffet dinner
7:00 p.m.	Reference Committees

Second day: (Saturday)

9:00 a.m.	Call to Order and Program in Medical-Socio-Economics
10:30 a.m.	Reference Committee Reports
12 Noon	Buffet lunch and Adjournment at Conclusion of Reports

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BY-LAWS—It recommended acceptance of the "Statement by the Council on the Desirability of Two Meetings of the House of Delegates a Year, the First Such Year to be 1963." The Committee also noted that it was not necessary to amend the Constitution and Bylaws to make this effective, although it might be desirable to do so at a later date.

HOUSE OF DELEGATES ACTION—Accepted the recommendation of the Reference Committee.

■ 1962 ANNUAL REPORT OF THE COMMISSION ON MEDICAL CARE PLANS

E. M. Dessloch, M.D., Prairie du Chien, Chairman

The year 1962 saw the State Medical Society's own voluntary, prepaid medical care plan reach a stage of vigorous maturity. Important goals, long desired, have been attained:

. . . Surpassed the $10 million mark in earned premiums by more than a million dollars
. . . Pushed the surgical-medical contract count over 100,000 once again
. . . Increased reserves to an all-time high (almost $2½ million)
. . . Consolidated the entire staff of Wisconsin Physicians Service under one roof.

While it is recognized that there are still problems to be overcome and further objectives to be reached, it is with a feeling of extreme optimism that this report of progress is presented.

Earned Premiums

Paralleling the growth in contract count, earned premiums continued the upward trend of recent years. This not only reflects the enrollment of a segment of the American Motors group, but upgrading of coverage and increased enrollments in most coverage categories. As indicated by the chart to the right, earned premiums exceeded eleven million dollars ($11,034,739). They are projected to be in excess of $13,000,000 for 1963.

It is interesting to note that premium income has more than doubled (from $5,308,167 to $11,034,739) in the five years since 1957, and that by the end of 1963 it will have grown to 2½ times that of 1957. Along with this growth has come stability, as indicated in other financial data.

Loss Ratios

The percentage relationship which claims incurred bear to earned premiums is commonly known as "loss ratio." It represents the portion of each earned premium dollar which is disbursed in the payment of contract benefits or which is set aside for claims received and not paid plus claims not reported but anticipated. The 1962 loss ratio for all claims (both surgical-medical and hospital) was 85 percent. This favorable result reflects the stability WPS has attained through its growth and maturity and the efforts of Claims personnel and the Medical Consultant to control benefit payments within contract provisions.

One question which has been continually raised in appraisal of WPS is that of its ability to successfully develop and administer a hospital contract. This question was well answered during 1962 in that total hospital contract count was at an all time WPS high, with a loss ratio of 87.9%, a figure *lower* than that of its largest area competitor.

Expense Ratio

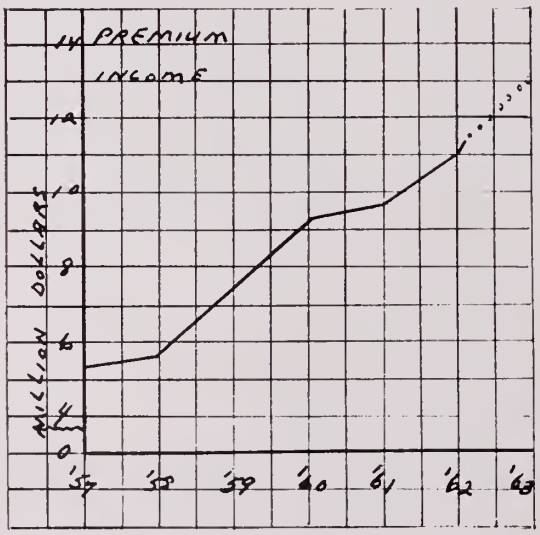
The ratio of administrative expenses to earned premiums is widely referred to as the "expense ratio." In 1962 the expense ratio remained within the 12% objective at 11.7%. An expanded program of advertising and promotion was a contributing factor to the slight rise from the previous year.

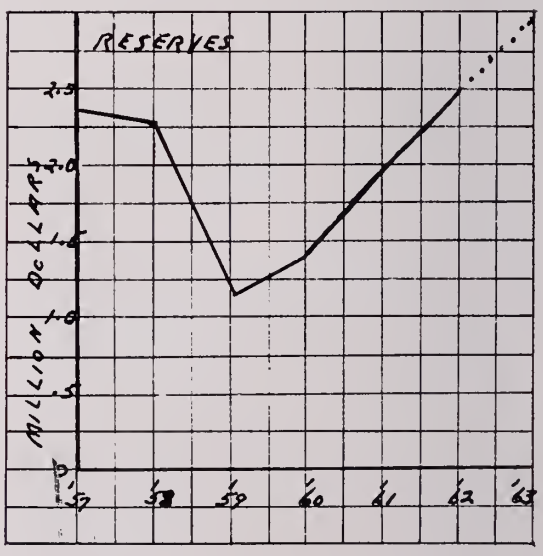
Investment Income

Investment and other income totaled $159,356 in 1962 as compared to $114,720 in 1961. The improvement is due to the expansion in total funds available for investment and an increase in the yield realized.

Diversification of the WPS portfolio continued during 1962 as indicated by the following tabulation:

	Percent of Total Investments	
	12/31/61	*12/31/62*
Government Securities	90.1%	77.7%
Commercial Securities	1.6%	8.7%
Other Investments	8.3%	13.6%
Total Investments	100.0%	100.0%





Total Reserves

The amount in "Reserves" basically represents prior earnings set aside to cover unforeseen contingencies in the future. As indicated by the chart, reserves totalled $2,479,817 at December 31, 1962, which represents the all-time high during the history of Wisconsin Physicians Service.

The chart also shows the consistent growth in reserves during the last three years (projected for 1963), thereby attesting to the financial stability which WPS has attained.

Enrollment

The stepped-up program of aggressive promotion and advertising in 1962 contributed to an increase in contract count in all categories. As shown by the following comparison, there were substantial increases in hospital, major medical and surgical-medical coverage with surgical-medical contracts once again exceeding 100,000.

	12/31/61	*12/31/62*
Surgical-Medical	99,247	117,097
Hospital	43,954	49,861
Major Medical	17,228	22,995
Total	160,429	189,953

One means of evaluating growth is through comparison with other plans of similar purpose and program. In 1962, WPS increased its surgical-medical contract count by 16.4% while its largest area competitor increased its count by 10.7%.

WPS was successful in retaining a high percentage of "old" subscribers with individual contracts and in groups. The addition of a new large risk, American Motors Corporation, combined with the retention of its two largest risks—State of Wisconsin Employees and General Motors Employees at Janesville, Wisconsin contributed substantially to a good enrollment picture.

In non-group coverage a most significant factor was the increase in Century Plan contracts from 7,268 in 1961 to 11,197 in 1962. This increase reflects the desire of the Commission on Medical Care Plans to continually expand health care benefits in areas in which they are particularly needed.

Another area in which strong efforts were made to give needed benefits was that of "upgrading" subscribers. A sustained campaign to upgrade benefits from "B" to "A" schedule contracts resulted in better coverage for a substantial number of subscribers. A similar program will continue in 1963.

Claim Payments

In 1962 WPS paid 104,845 claims submitted by physicians on behalf of subscribers and 31,727 hospital claims. These accounted for total benefit payments of $9,468,532—an increase of $1,374,000 over the prior year. The increase in benefit payments was a natural consequence of increased contract volume.

Special Service contracts comprised over 60% of surgical-medical coverages for WPS subscribers in 1962. Keeping this in mind, it is important to realize that *less* than 1% of all claims needed special attention from County Advisory Committees. All others were handled through direct processing of the Claims Department.

A constant vigil has been maintained on benefit utilization so that WPS can act promptly upon recommendations of the actuary. The present trend indicates that rate increases in some categories may be necessary in the near future.

In the claims area, "tailor-making" of contracts to meet the requirements of certain large groups is bringing about the identification of contracts by name, such as the State Employees contract, General Motors' contract, and Select Risk. These variations in contract require special handling by the Claims Department and machinery has been developed to quickly and efficiently process claims for these groups.

Service Improvement

In accord with the goals of the Commission on Medical Care Plans, the Research Division of WPS was engaged in projects covering many areas of health care. These studies included:

. . . home care situation in Wisconsin
. . . revision of the guide to members of county advisory committees
. . . tailor-making of contracts
. . . review of SMS employees health program
. . . studies of numerous questions relating to WPS contracts

In addition, a major project in which the Research Division participated was that of making the "big move" to new quarters within the State Medical Society headquarters. This move was coordinated with the Office Services Director and the goal of bringing all Wisconsin Physicians Service employees under one roof was achieved with a minimum of service interruption.

Important changes in office procedures accompanied the move to new quarters. Development of a central filing system and a centralized secretarial service have aided the staff in giving more efficient service to subscribers.

Cognizant of the always-present need for faster and more efficient service, the Commission on Medical Care Plans authorized expansion of the data processing system. New programmers have already been employed to implement addition of the new IBM 1440 program in 1964.

Promotional Program

The $100,000 Wisconsin Physicians Service promotional program expanded into state-wide newspapers, magazines and the Wisconsin edition of the *Saturday Evening Post*, as well as direct mail and special advertising projects.

Fall promotional efforts were aimed at emphasizing WPS Century Plan through a hard-hitting tie-in campaign coordinated with the National Blue Shield Senior Citizens promotion.

Major medical coverages were introduced through state-wide advertising and direct mail promotions resulting in the establishment of "WPS Ready Reserve" and "WPS Protection Plus" as contracts worthy of special consideration.

For the first time major illness contracts were made available to non-group subscribers.

Working closely with its actuarial consultant, WPS developed a health care contract to provide benefits for prescription drugs. Cooperation with representatives of the State Dental Society is paving the way toward an oral surgery contract. Again, comprehensive advertising programs have been developed to introduce them to the public.

Another important part of the program was a comprehensive updating of brochures, letters and forms to facilitate new business sales and to provide better service to present subscribers.

Agency Expansion

The number of WPS agencies increased during the past year to 75, a net increase of 43 over 1961. Agency expansion necessitated an increase in supervisory personnel in this department, both in the home office and in the field.

In addition to the enlarged agency sales force, there was a broadening of the market for agency personnel. It was permitted to sell franchise group, small group and, in some instances, large group.

Business from this source *tripled* in volume during 1962.

Hospital Relations

During 1962 the Administrator, Hospital Relations, continued his public relations work with physicians, hospitals and others.

In addition, he engaged in many other WPS activities, such as working with the Underwriting Director and the Kenosha County Advisory Committee in administration of the American Motors contract. A review of the year shows that such programs as the First Annual Work Week of Health and other activities of the total Society are becoming an increasing part of his job.

Medicare

Wisconsin physicians received $550,000 in payment for care of military dependents in 1962. Along with these payments, WPS provided services to five neighboring states to assist them in processing more than 18,000 cases for which payments totaled nearly $1,500,000.

During the year WPS was able to decrease its administrative cost per claim because of increased volume of cases due to the activation and subsequent de-activation in 1962 of Wisconsin's 32nd Division.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BY-LAWS—The Committee commended the Commission on Medical Care Plans for its direction of Wisconsin Physicians Service and the progress made in attaining desired goals. It recommended acceptance of the report, with the following request: That since WPS is the largest single activity of the State Medical Society, it is your committee's belief that in the future this report should be more detailed and include a financial report.

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Reference Committee.

■ 1964 DUES

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BY-LAWS—A majority report of the Committee recommended that 1964 dues be reduced to $80.00. A minority report of the Committee suggested that the determination of 1964 dues be held until the second session of the House of Delegates, and that the whole subject be laid over until October.

HOUSE OF DELEGATES ACTION—Rejected the majority report of the Reference Committee.

■ EXTRAORDINARY SESSION

An extraordinary session to present the Booz, Allen and Hamilton management survey report was held in executive session between the first and second sessions of the House of Delegates.

Following presentation of the report, Dr. H. M. Suckle, Madison, chairman of the management survey committee, entered a motion as follows:

"That the House of Delegates receive the Booz, Allen and Hamilton survey without recommendation and that a seven-man committee be appointed to review and study the survey and make appropriate recommendations in the form of resolutions to the House of Delegates at the next meeting of the House following this present annual session. It is also moved that the committee consist of two members of the State Medical Society appointed by the incoming president of the Society; two appointed by the Chairman of the Council; and three appointed jointly by the incoming speaker and incoming vice-speaker of the House of Delegates, and that the President of the Society, the Speaker and Vice-Speaker of the House of Delegates serve as ex officio members of this committee.

HOUSE OF DELEGATES ACTION—Adopted the motion.

■ REMARKS OF THE SECRETARY

Mr. C. H. Crownhart, Madison

One matter of business which the House has not settled, on which the staff needs direction, relates to the distribution of the Booz, Allen and Hamilton Report.

The report was submitted to the House. The Secretary has assumed that the distribution is limited to the House of Delegates and the Alternates. The Secretary also assumes there may be doctors out in the state who would like to read it.

The expense of printing that report was about $7 a copy. We ran, possibly, 700 more than were needed here. It has been the thought of the Secretary's office, that those copies be made available to interested members on a loan basis, so, if we run out of the 700, they can be returned when the members are finished and sent out to somebody else. At $7 a copy, it doesn't seem entirely wise to run around 3800 copies so that all of the money in the reserve of the Management Study would be depleted.

MOTION—A copy of the Booz, Allen and Hamilton Report be sent to each county medical society and be available on loan to every member of the Wisconsin State Medical Society upon request.

HOUSE OF DELEGATES ACTION—Adopted the motion.

MOTION—County medical societies be instructed to hold a meeting for consideration of this report.

HOUSE OF DELEGATES ACTION—Adopted the motion.

SECRETARY'S REMARKS—*continued*

We, in the State Office, do our best to convey messages and information as effectively and efficiently as possible. The Booz, Allen and Hamilton Report noted that some people said there was too much mail from Madison. Other physicians of the one hundred interviewed apparently indicated they didn't get enough mail from Madison.

One of the sources of information for county medical societies should be that of the Councilor. I am aware of the fact that, in some areas of the state, the Councilor representing the district is not notified of the county medical society meeting. Yet, one of his duties is to be available to meetings of the county medical society, to tell you the actions of the Council, to explain them in greater detail if you wish them, and to bring your reactions back to Council meetings.

We have a rather large number of officers in attendance at every Council meeting, including the Vice-Speaker, the Speaker of the House of Delegates; the four AMA delegates are always invited, as are the alternates. When you add all these together, if it keeps on growing, we are going to have to have badges, so everybody will know each other.

Nevertheless, these men from all over the state are available to you, and I would like to assure you again of the availability of the Secretary. There was a time when the Secretary's office covered approximately 25 county medical society meetings a year. The representatives of the office were available to discuss any of the problems that might occur. That type of information may be due in some respect to the fact that I do a lot of traveling, and I know our office is not called upon with the frequency it used to be.

But one more point, when we get back to Madison and duly recover, I think, we will send to all of you the name and address of your incoming President, his telphone number, and any other information that you may wish. These men are also the emissaries of your State Society, and they should be

invited to the extent you can fit them into your program. The energy Doctor Egan has shown this year —I don't think he missed a meeting; maybe one of a committee—these men are serving hard, and they are available to you.

INTRODUCTION OF GUESTS

Dr. Donald McCarthy, of Minneapolis, president of the Minnesota State Medical Association, was introduced.

■ COMMITTEE ON NOMINATIONS

District	*Nominee*
First	Robert Monk, M.D., Waukesha
Second	Richard W. Ashley, M.D., Kenosha
Third	H. M. Suckle, M.D., Madison
Fourth	W. D. Hamlin, M.D., Mineral Point
Fifth	A. C. Engel, M.D., New Holstein
Sixth	David J. Twohig, Jr., M.D., Fond du Lac
Seventh	G. B. Murphy, Jr., M.D., La Crosse
Eighth	Donald A. Jeffries, M.D., Shawano
Ninth	E. C. Glenn, M.D., Wisconsin Rapids
Tenth	L. O. Simenstad, M.D., Osceola
Eleventh	C. J. Picard, M.D., Superior
Twelfth	A. J. Sanfelippo, M.D., Milwaukee
Thirteenth	Marvin Wright, M.D., Rhinelander

HOUSE OF DELEGATES ACTION—Accepted the Committee on Nominations as selected by each district in caucus.

■ INTRODUCTION OF RESOLUTION

E. J. Nordby, M.D., Madison

WHEREAS, the implementing committee for the study and recommendations of the Booz, Allen and Hamilton Report will or may require special and technical assistance to accomplish its work; and

WHEREAS, Funds are remaining from those collected for the management survey; therefore, be it

Resolved, That the remaining funds as necessary be available to the implementing committee for purposes of accomplishing its directives before reverting to the general fund.

I move adoption of this resolution.

HOUSE OF DELEGATES ACTION—It authorized the use of remaining funds from the management survey to implement the new committee as authorized in the Extraordinary Session.

■ REPORT OF COMMITTEE ON NOMINATIONS

C. J. Picard, M.D., Superior, Chairman

The following nominees were presented for positions in the State Medical Society as follows:

President-elect—W. P. Curran, M.D., Antigo (to succeed W. J. Egan, M.D., Milwaukee).

Speaker—R. E. Callan, M.D., Milwaukee (to succeed himself).

Vice-Speaker—H. W. Carey, M.D., Lancaster (to succeed himself).

Delegates to AMA—A. A. Quisling, M.D., Madison (1964–1965) (to succeed himself); R. E. Galasinski, M.D., Milwaukee (1964–1965) (to succeed himself).

Alternate delegates to AMA—W. B. Hildebrand, M.D., Menasha (1964–1965) (to succeed himself); G. E. Collentine Jr., Milwaukee (1964–1965) (to succeed himself).

HOUSE OF DELEGATES ACTION—The Secretary was asked to cast a unanimous ballot of the House for all nominees.

■ ELECTION OF COUNCILORS

Nominations for councilors were presented by the elected delegates of the county medical society or societies in the district which the councilor represented as follows:

District	*Nominee*
First	W. D. James, M.D., Oconomowoc (to succeed himself)
Second	G. J. Schulz, M.D., Union Grove (to succeed himself)
Third	C. W. Stoops, M.D., Madison (to succeed J. H. Houghton, M.D., Wisconsin Dells)
Eleventh	V. E. Ekblad, M.D., Superior (to succeed himself)
Twelfth	L. J. Van Hecke, M.D., Milwaukee (to succeed himself)
	W. J. Houghton, M.D., Milwaukee (to succeed himself)
Thirteenth	Marvin Wright, M.D., Rhinelander (to succeed W. P. Curran, M.D., Antigo)

HOUSE OF DELEGATES ACTION—Approved the nominations for councilors as recommended by the respective districts.

■ SITE OF 1964 ANNUAL MEETING

The Committee on Nominations recommended that Milwaukee be the site of the 1964 annual meeting.

HOUSE OF DELEGATES ACTION—Approved Milwaukee as the site of the 1964 annual meeting.

■ RESOLUTION OF APPRECIATION

F. E. Drew, M.D., Milwaukee

As you well know, there are two faces that have been absent at this session, and I think it is very fitting that we recognize their absence at this time.

Mrs. Charlotte Emmons and Mr. Roy Ragatz have not been able to attend the sessions, and I would like to make this motion, and ask that the House send wires to these two individuals.

The motion reads:

In appreciation of many years of faithful service to the Medical Society of the State of Wisconsin, we wish to express our sincere thanks, and wish you a speedy recovery from your recent illness.

Signed by the House of Delegates.

HOUSE OF DELEGATES ACTION—Motion carried.

■ REMARKS OF SECRETARY

Mr. C. H. Crownhart, Madison

The fall meeting of the House of Delegates has been scheduled for Friday and Saturday, October 18 and 19, at the State Medical Society Headquarters in Madison.

■ COMMITTEE ON CREDENTIALS

T. J. Nereim, M.D., Madison, Chairman
D. J. Carlson, M.D., Milwaukee
W. D. Hamlin, M.D., Mineral Point

HOUSE OF DELEGATES ACTION—Accepted as the official roll of the first session of the House 86 delegates and 4 alternate delegates, totaling 90, entitled to vote.

Accepted as the official roll of the second session of the House 57 delegates and 2 alternate delegates, totaling 59, entitled to vote.

Accepted as the official roll of the third session of the House 82 delegates and 4 alternate delegates, totaling 86, entitled to vote.

ATTENDANCE AT HOUSE OF DELEGATES

	Sessions 1	2	X	3
SOCIETY:				
Ashland—Bayfield—Iron				
J. M. Jauquet, Ashland	o	o	o	o
C. A. Grand, Ashland	x	x	x	x
Barron—Washburn—Sawyer—Burnett				
C. J. Strang, Barron	x	x	x	x
Robert Anderson, Cumberland	o	o	o	o
Brown				
B. P. Waldkirch, De Pere	x	x	x	x
Donel Sullivan, Green Bay	x	o	o	o
J. L. Ford, Green Bay	x	x	x	x
L. H. Edelblute, Green Bay	x	x	x	x
Calumet				
E. W. Humke, Chilton	o	o	o	o
A. C. Engel, New Holstein	x	x	x	x
Chippewa				
M. W. Asplund, Bloomer	o	o	o	o
J. J. Sazama, Chippewa Falls	o	o	o	o
Clark				
M. V. Overman, Neillsville	x	x	x	x
R. L. Hansen, Colby	o	o	o	o
Columbia—Marquette—Adams				
R. R. Rueckert, Portage	x	x	x	x
R. T. Cooney, Portage	x	x	x	x
Crawford				
M. S. Garrity, Prairie du Chien	x	x	x	x
T. F. Farrell, Prairie du Chien	o	o	o	o
Dane				
R. L. Beilman, Madison	o	x	x	x
F. D. Bernard, Madison	o	o	o	o
T. J. Nereim, Madison	x	x	x	x
K. L. Siebecker, Madison	x	x	x	x
R. N. Allin, Madison	x	x	x	x
A. J. Richtsmeier, Madison	x	x	o	o
N. M. Clausen, Madison	x	x	x	x
R. P. Sinaiko, Madison	o	x	o	o
H. M. Suckle, Madison	x	x	x	x
A. E. Cowle, Madison	o	o	o	o
C. W. Stoops, Madison	x	x	x	x
P. B. Golden, Madison	o	o	o	o
W. T. Russell, Sun Prairie	x	x	x	x
G. J. Derus, Madison	x	x	x	x
R. A. Straughn, Madison	x	x	x	x
G. E. Oosterhous, Madison	x	o	o	o
Dodge				
L. W. Schrank, Waupun	x	x	x	x
R. E. Urbanek, Beaver Dam	o	o	o	o
Door—Kewaunee				
W. G. Sheets, Sturgeon Bay	x	x	x	x
D. E. Dorchester, Sturgeon Bay	x	x	x	x
Douglas				
C. J. Picard, Superior	x	x	x	x
R. P. Fruehauf Superior	x	x	x	x
Eau Claire—Dunn—Pepin				
D. R. Griffith, Eau Claire	x	x	x	x
G. G. Giffen, Eau Claire	o	o	o	o
A. A. Drescher, Menomonie	x	x	x	x
W. R. Manz, Eau Claire	x	x	o	x
Fond du Lac				
D. J. Twohig, Jr., Fond du Lac	x	x	x	x
W. E. Myers, Fond du Lac	o	x	x	x

First name is delegate, indented name is alternate. x—present. o—absent. X—extraordinary session.

	Sessions 1	2	X	3
Forest				
E. F. Castaldo, Laona	o	o	o	o
B. S. Rathert, Crandon	o	o	o	o
Grant				
H. W. Carey, Lancaster	x	x	x	x
C. L. Steidinger, Platteville	x	x	x	x
Green				
R. G. Zach, Monroe	x	x	x	x
W. J. Staab, Jr., Monroe	x	x	x	x
Green Lake—Waushara				
C. A. Klasinski, Wautoma	o	o	o	o
David Sievers, Berlin	o	o	o	o
Iowa				
W. D. Hamlin, Mineral Point	x	x	x	x
S. B. Marshall, Hollandale	o	o	o	o
Jefferson				
J. J. Voytek, Fort Atkinson	x	o	x	x
R. R. Liebenow, Lake Mills	o	x	o	o
Juneau				
J. S. Strong, Mauston	o	x	x	x
M. S. Tverberg, Mauston	o	o	o	o
Kenosha				
R. W. Ashley, Kenosha	x	x	x	x
G. C. Schulte, Kenosha	o	o	o	o
La Crosse				
G. B. Murphy, Jr., La Crosse	x	x	x	x
F. H. Wolf, La Crosse	o	x	x	x
D. L. Morris, West Salem	x	x	o	o
G. E. Skemp, La Crosse	o	x	x	x
Lafayette				
R. E. Oertley, Darlington	x	x	x	x
L. J. Unterholzner, Blanchardville	o	o	o	o
Langlade				
W. P. Curran, Antigo	x	x	x	x
D. W. Dailey, Elcho	o	o	o	o
Lincoln				
R. J. Henderson, Tomahawk	x	x	x	x
J. F. Bigalow, Merrill	x	x	o	o
Manitowoc				
T. H. Rees, Manitowoc	x	x	x	x
W. F. Smejkal, Manitowoc	x	x	x	x
Marathon				
E. P. Ludwig, Wausau	x	x	x	x
A. H. Stahmer Wausau	x	x	o	o
Marinette—Florence				
J. W. Boren, Jr., Marinette	x	x	x	x
C. E. Koepp, Marinette	o	o	o	o
Milwaukee				
V. L. Baker, Milwaukee	x	o	o	o
R. T. Sproule, Milwaukee	x	o	x	o
N. G. Bauch, Milwaukee	x	x	x	x
W. L. Coffey, Milwaukee	x	x	o	o
E. L. Bernhart, Milwaukee	x	x	x	x
L. E. Rothman, Milwaukee	o	o	o	o
D. J. Carlson, Milwaukee	x	x	x	o
R. B. Pittelkow, Milwaukee	x	x	o	o
J. F. Cary, Milwaukee	o	o	o	o
R. A. Nimz, Milwaukee	x	x	o	o
E. D. Wilkinson, West Allis	x	o	x	x
Rex Ruppa, Milwaukee	x	o	o	o
G. E. Collentine, Jr., Milwaukee	x	x	x	x
John Bareta, Milwaukee	o	o	o	o
E. G. Collins, West Allis	x	x	x	x
F. J. Millen, Milwaukee	x	o	x	x
W. J. Conen, Milwaukee	x	x	x	x
E. J. Schmidt, Wauwatosa	x	x	o	o
F. E. Drew, Milwaukee	x	o	x	x
P. G. LaBissoniere, Milwaukee	x	o	o	o
Edgar End, Milwaukee	x	x	x	x
G. W. Dean, Milwaukee	x	o	x	x

	Sessions 1	2	X	3
Norbert Enzer, Milwaukee	o	o	o	o
R. H. Lillie, Milwaukee	o	o	o	o
G. W. Hilliard, Milwaukee	x	x	x	x
T. F. Jennings, Milwaukee	o	o	x	x
G. S. Kilkenny, Milwaukee	x	x	o	o
R. J. Snartemo, Milwaukee	x	o	x	o
H. M. Klopf, Milwaukee	x	o	o	o
B. J. Peters, Milwaukee	o	o	o	o
H. J. Lee, Milwaukee	o	o	o	o
W. H. Frackelton, Milwaukee	o	o	o	o
George Murphy, South Milwaukee	x	x	o	x
R. H. Frederick, West Allis	o	o	o	o
P. E. Oberbreckling, Milwaukee	x	x	x	x
A. E. Roethke, Milwaukee	o	o	o	o
R. F. Purtell, Milwaukee	x	x	x	x
Roger Laubenheimer, Milwaukee	x	o	x	o
F. A. Ross, Milwaukee	x	o	o	o
T. J. Cox, Milwaukee	x	o	o	o
D. M. Ruch, Milwaukee	x	o	x	o
K. A. Liefert, Wauwatosa	x	x	x	x
A. J. Sanfelippo, Milwaukee	x	o	x	x
J. R. O'Connell, Milwaukee	x	o	o	o
C. M. Schroeder, Milwaukee	x	x	x	x
K. E. Sauter, Milwaukee	x	o	x	x
H. F. Twelmeyer, Wauwatosa	x	x	x	x
D. W. Calvy, Milwaukee	x	o	o	o
L. R. Weinshel, Milwaukee	x	x	x	x
W. S. Polacheck, Milwaukee	o	o	o	o
S. E. Zawodny, Milwaukee	x	o	o	x
J. R. Evrard, Milwaukee	o	o	o	o
Monroe				
C. B. Koch, Lisbon	o	o	o	o
R. G. Konicek, Tomah	o	x	o	o
Oconto				
H. A. Aageson, Oconto	o	o	o	o
J. R. Culver, Oconto Falls	o	o	o	o
Oneida—Vilas				
Marvin Wright, Rhinelander	x	x	x	x
L. L. Jacobson, Eagle River	o	o	o	o
Outagamie				
G. A. Behnke, Kaukauna	x	x	x	x
W. H. Hale, Appleton	x	x	x	x
J. G. Bergwall, Hortonville	o	o	o	o
Ozaukee				
J. F. Walsh, Port Washington	x	x	x	x
R. H. Dorr, Belgium	x	x	o	o
Pierce—St. Croix				
C. A. Olson, Baldwin	x	x	x	x
O. H. Epley, New Richmond	o	o	o	o
Polk				
L. O. Simenstad, Osceola	x	x	x	x
R. M. Moore, Frederick	o	o	o	o
Portage				
F. E. Gehin, Stevens Point	x	x	x	x
A. J. Sowka, Stevens Point	o	x	o	o
Price—Taylor				
R. E. Nystrum, Medford	x	x	x	x
W. W. Meyer, Medford	o	o	o	o
Racine				
L. E. Fazen, Jr., Racine	x	x	o	o
V. J. Burch, Racine	o	o	x	x
G. L. Rothenmaier, Racine	o	x	x	x
W. F. Henken, Racine	x	o	o	o
Richland				
R. E. Housner, Richland Center	x	o	o	o
D. J. Taft, Richland Center	o	o	x	x
Rock				
M. F. Purdy, Janesville	o	x	x	x
M. J. Roesler, Janesville	x	o	o	o
D. M. Clark, Beloit	x	x	x	x
J. C. Beltran, Beloit	o	o	o	o

	Sessions 1	2	X	3
Rusk				
H. F. Pagel, Ladysmith	o	o	o	o
M. L. Whalen, Bruce	x	x	x	x
Sauk				
E. V. Stadel, Reedsburg	x	x	x	x
J. A. Tibbitts, Reedsburg	o	o	o	o
Shawano				
D. A. Jeffries, Shawano	x	x	x	x
H. F. Laufenburg, Shawano	o	o	o	o
Sheboygan				
J. W. McRoberts, Sheboygan	x	o	o	o
D. M. Rowe, Kohler	o	x	o	o
Trempealeau—Jackson—Buffalo				
E. P. Rohde, Galesville	x	x	x	x
W. E. Wright, Mondovi	x	x	x	x
Vernon				
W. N. Otterson, Viroqua	x	x	o	o
Thomas Boston, Hillsboro	o	o	o	o
Walworth				
J. E. Martin, Jr., Delavan	x	x	x	x
R. S. Galgano, Delavan	o	o	x	o
Washington				
E. C. Quackenbush, Hartford	x	x	x	x
W. A. Nielson, West Bend	o	o	x	o
Waukesha				
J. V. Bolger, Jr., Waukesha	x	x	x	x
Clarence Samuelson, Hartland	o	o	o	o
Robert Monk, Waukesha	x	x	o	o
Loren Driscoll, Oconomowoc	o	o	o	o
Waupaca				
O. E. Larson, Clintonville	o	o	o	o
M. O. Boudry, Waupaca	o	o	o	o
Winnebago				
C. G. Kirchgeorg, Neenah	x	o	x	x
H. J. Colgan, Neenah	o	o	o	o
E. A. Strakosch, Oshkosh	x	x	x	x
S. J. Graiewski, Oshkosh	x	x	o	o
Wood				
E. C. Glenn, Wisconsin Rapids	x	x	x	x
W. B. Larkin, Marshfield	x	x	x	o
SECTION:				
Dermatology				
Joel Taxman, Milwaukee	x	x	x	x
James Bringe, Sheboygan	o	o	o	o
General Practice				
R. R. Richards, Eau Claire	x	x	x	x
J. E. Kelble, Milwaukee	x	x	x	x
L. J. Kurten, Racine	o	o	o	o
R. L. Gilbert, La Crosse	o	o	o	o
Neurology—Psychiatry				
K. M. Keane, Appleton	o	x	o	x
R. E. O'Connor, Madison	o	o	o	o
Obstetrics—Gynecology				
D. O. Price, Madison	x	x	x	x
Ophthalmology—Otolaryngology				
R. T. Schmidt, Green Bay	o	o	x	x
F. G. Treskow, Milwaukee	x	o	o	o
Orthopedics				
J. O. D. McCabe, Milwaukee	x	o	x	x
John Van Driest, Sheboygan	o	o	o	o
Pathology				
J. L. Teresi, Milwaukee	x	o	x	o
L. W. Kleppe, Beloit	o	o	x	x
Pediatrics				
K. J. Winters, Wauwatosa	x	o	x	x
Richard Myers, Green Bay	o	o	o	o

	Sessions 1	2	X	3
Public Health				
G. M. Shinners, Green Bay	x	x	x	x
E. E. Bertolaet Milwaukee	o	o	o	o
Radiology				
Howard Mauthe, Racine	x	x	x	x
L. E. Jones, Racine	o	x	o	o

	Sessions 1	2	X	3
Surgery				
J. T. Mendenhall, Madison	x	x	o	o
R. B. Larsen, Wausau	o	o	x	x
Urology				
F. M. Hilpert, Racine	x	x	o	x
A. J. Jacobsen, Racine	o	o	o	o

A POSSIBLE BREAK FOR ASTHMA SUFFERERS

Australian scientists have found a mysterious substance in the lungs of asthma sufferers that could lead to a vital breakthrough in the fight against this condition. Prof. D. L. Wilhelm, head of the School of Pathology at the University of New South Wales said that this new substance may initiate asthmatic attacks. Once isolated and identified scientists will try to discover a neutralizing drug for it. To date the substance is nameless and known merely as SRS—slow reacting substance.—JOURNAL OF THE INDIAN MEDICAL ASSOCIATION 40: 8:387, as reported in news release of the United States Committee of the World Medical Association.

DRUG SAFETY CANNOT BE LEGISLATED

The fundamental lesson that can be drawn from our experience thus far with the new (FDA) clinical regulations is an old one: morals cannot be legislated. Most pharmaceutical firms are irked, of course, that they are now being compelled by law to document massively the steps they were taking before, quite voluntarily, based on good business practice and a feeling of public responsibility and pride in their products. The necessity for putting every detail on paper is both frustrating and time-consuming. Drug safety requires scientific judgment, which cannot be legislated. Most companies take far greater precautions than called for by the law, because their business sense and scientific judgment calls for such precautions. They know that if anything goes wrong, liability will rest with the drug manufacturer and not the Food and Drug Administration.—AUSTIN SMITH, M.D., to American Psychiatric Association, St. Louis, Mo., May 7, 1963.

GYNECOLOGISTS PUBLISH TWO NEW BOOKLETS

Two new booklets—"Dental Care Before the Baby Is Born" and "FACOG" were published this month by The American College of Obstetricians and Gynecologists for educational distribution.

"Dental Care Before the Baby Is Born" was prepared by the American Dental Association and the ACOG. It spells out dental care for the mother, as well as preparation for the infant's tooth development, dispelling a few "old wives' tales".

"FACOG" explains the meaning of these initials (Fellow of The American College of Obstetricians and Gynecologists) when used after a doctor's name.

These booklets are part of the newly expanded ACOG public education program to continue the series begun with "What Is A Gynecologist?" two years ago. A sample copy of each booklet may be obtained by writing to: The ACOG, Booklet Dept., 74 West Monroe St., Chicago, Ill. 60603. Bulk supplies may be purchased at cost.

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If you are interested in medical writing, in educational processes, in editing, publishing, or any other aspects of medical communication—then you may profit by becoming a member of the American Medical Writers' Association.

AMWA, now 20 years old, is a national professional society of people who are engaged or interested in medical communications. It stages an annual 2-day convention (Chicago in '63; Philadelphia in '64); provides a medical manuscript editing service and a national placement service for members; grants awards and certificates for outstanding accomplishments in medical writing and editing; judges medical writing contests, maintains a roster of lecturers on medical writing, and offers scholarships for people contemplating a career in this field.

AMWA publishes a monthly *Bulletin* as well as pamphlets on various aspects of medical writing. Chapters of AMWA are active in the metropolitan New York, Chicago, Philadelphia, Washington, Detroit and San Francisco areas.

AMWA membership embraces editors and publishers in the field of medicine, dentistry, nursing and allied professional groups; writers and editors associated with hospitals, pharmaceutical companies, foundations, publishing houses and advertising agencies—and many physicians who are interested in problems of medical communications, or who just want to write more effectively. Dues are $10.00 a year. AMWA's national office is at 250 West 57th Street, New York 19, New York.

the wisconsin medical journal

VOLUME 62/NUMBER 12 DECEMBER 1963

Esophageal Hiatus Hernia

By IVAN D. BARONOFSKY, M.D., Ph.D.
San Diego, California

■ WE BELIEVE that symptomatic hiatus hernia is a surgical problem which if not corrected may lead to serious complications. We have no desire to please any particular group of surgeons in advocating an abdominal versus thoracic approach. A good repair from either side of the diaphragm is a welcome relief to a patient. Yet because of certain experiences in the last eight years, we have used the abdominal approach more and more frequently. Hence, we believe that it is important for general surgeons to master the technique of abdominal repair of hiatus hernia. We want to present our reasons for the preferred approach as evidenced by our own experience and that reported in the literature.

Clinical Material. During the past eight years, operation was performed on a series of patients with esophageal hiatus hernia. Three locations were utilized: one hospital including only service-connected personnel; one hospital in a large metropolitan area; and one, the present, in private practice. Because of the difficulty in following up the first group, most of the material was based on the latter two groups (30 patients). However, because of our present location, the aforementioned service hospital, the first group of patients is interviewed occasionally on a nonselective basis. The opinions and facts can be applied to any of the three groups. Also, clinical material from the literature has been collected.

Symptomatology. From a study of our cases and those in the literature, it is evident that the main symptoms of esophageal hiatus hernia simulate primarily those of abdominal organ disease (Table 1) and often cannot be diagnosed correctly until the abdominal cavity has been adequately explored. It will be noted that the symptoms as presented in Table 1 are purely alimentary tract symptoms.

Associated Intra-abdominal Problems. Associated intra-abdominal problems were encountered in 30 per cent of our cases of abdominal exploration. Five patients had associated peptic ulcer, and six had gallbladder disease. In a similar series in the literature,[1] other intra-abdominal problems occurred in 44 per cent of the entire group. In another series of 25 patients who were operated by the transabdominal route, diseased gallbladder was found and removed in 15. Seven of these patients also had duodenal ulcer. In the same series, 28 additional procedures were performed which would have been impossible if the patients had been operated by the transthoracic route. The transthoracic route was used for another series of 20 patients,[2] 10 of whom had such associated pathologic conditions as ulcer, cholelithiasis, carcinoma of colon, carcinoma of

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Doctor Baronofsky is Clinical Professor of Surgery, University of Southern California School of Medicine, and a member of Scripps Clinic, La Jolla, Calif.

Presented as the Beaumont Memorial Lecture before the Wisconsin Surgical Society at the 122nd Annual Meeting of the State Medical Society of Wisconsin, May 9, 1963, Milwaukee.

stomach, duodenal diverticula, Meckel's diverticulum, hernia, leiomyoma, aneurysm, and common duct stone.

Results. Of the 30 patients presented in the series, 2 had recurrences as shown by roentgenography. It is interesting to note in both cases in which x-ray showed a recurrence that patients' symptoms have not recurred. Half of the patients had been operated using the thoracic route and half with the adbominal route. Most patients experienced improvement or disappearance of heartburn, epigastric pain, and regurgitation. Some patients experienced occasional regurgitation. One patient still has extreme nausea in the morning which is relieved by eating. New symptomatology at the incision site was present in most patients operated by the transthoracic route. Difficulty in eructation occurred in some patients (Table 2).

Associated Procedures. In our series, an associated procedure was performed in 30 per cent of the cases of abdominal repair. The presence of gallstones led to cholecystectomy. When esophagitis was present, vagotomy and pyloroplasty were also included. In one case, the presence of a Schatzki ring at the gastroesophageal junction required the resection of portions of the junctional muscle for complete relief. This was accomplished by a high gastrotomy from within the stomach.

TABLE 1—*Symptomatology of Patients With Esophageal Hiatus Hernia*

Data	Series	Literature			
Number of cases	30	90	20	138	22
Heartburn	25	63			
Epigastric pain	16		11	130	9
Bloating	18			14	
Nausea	17			10	
Vomiting	15	46		36	
Regurgitation	22		7	37	11
Substernal pain	16				22
Dysphagia	9	26	1	23	
Bleeding	6	36	8	62	5
Eructation	19			15	

TABLE 2—*Status of Symptoms Subsequent to Hiatus Hernia Repair*

Symptoms	Number
Heartburn	2
Epigastric pain	1
Bloating	5
Nausea	1
Vomiting	1
Regurgitation	4
Dysphagia	2
Melena	0
Substernal pain	1
Eructation	2
Pain in abdominal incision (15 cases, abdominal approach)	2
Pain in thoracic incision (15 cases, thoracic approach)	13

In the various series of hiatus hernias which were repaired transabdominally and reported in the literature,[1-4] associated procedures were performed in from 30 to 67 per cent of the cases. Esophagitis or duodenal ulcer was present in from 16 to 25 per cent. These problems led to definitive therapy in all cases. The associated procedures performed during abdominal repair of hiatus hernia were appendectomy, cholecystectomy, duodenal diverticulectomy, repair of incisional hernia, pyloroplasty, gastrectomy, gastroenterostomy, hysterectomy, colostomy, nephrectomy, sympathectomy, resection of aortic aneurysm, exploration of common bile duct, biopsy of pancreas for carcinoma, umbilical herniorrhaphy, removal of leiomyoma, and colectomy for carcinoma.

Comments. There is no doubt that a good surgeon can repair a diaphragmatic hiatus hernia using an approach from above or below the diaphragm. However, for succinct reasons, we are convinced that a subdiaphragmatic approach is better.

Clearly there are reasons for repair using an approach from above the diaphragm. In an obese person in whom exposure is obtained only with much tugging and tissue trauma, the approach from above the diaphragm may be simpler. The diaphragm acts as an excellent retractor, and the direct approach to the esophagus is not through the depths. Hernias complicated by organic obstruction may also require an approach from above as do those hernias associated with resectable lung disease. Yet it must be remembered that the diaphragmatic counterincision can be the source of immediate and subsequent trouble. Several cases of herniation through the radical incision in the diaphragm have been reported. From our own experiences in a service hospital, we would state that this herniation is more than an infrequent occurrence.

The frequent association of other disease entities with symptomatic hiatus hernia is significant. Gastroduodenal ulceration is estimated to occur in 10 to 30 per cent of patients with hiatus hernias. Thus, whenever esophagitis is present, search for gastroduodenal ulceration is mandatory. If hiatus hernia is present, the spasm associated with duodenal ulceration will increase the regurgitation of gastric juices leading to severe esophagitis. As a matter of fact, patients

with severe esophagitis with hernia should be treated with repair of hernia plus an acid-reducing procedure. It should be assumed that those patients who have severe esophagitis associated with hiatus hernia also have a severe ulcer diathesis.

More recently in certain cases, we have added vagotomy and pyloroplasty to the hernia repair. An overnight secretion is accomplished with a nasogastric tube in place. (This is inserted anyway as a preoperative measure.) If abnormal secretion is present, vagotomy and pyloroplasty are added. We believe this has been important in relieving future complications.

Another aspect to be considered is pain. We have found that the most distressing symptom present in those patients with hernias repaired transthoracically is pain at the incision site. Many patients have complained of severe pain lasting more than one month. They were also unable to lie or to sleep on the left (incision) side months after the procedure. This has not been the case with the abdominal approach.

Hiatus hernia is not a disease of young adults. We have shown that hiatus hernias tend to become larger with time.[5] Thus, symptomatically, hiatus hernias can cause trouble in patients in an age group that has associated lung and heart disease. The approach from the abdomen, as Beardsley[3] has pointed out, allows the patient to lie on his back in a relaxed fashion with both pleural cavities undisturbed. Respiratory efforts are notably much easier. With the chest open and the patient lying on his right side, it is common for both lungs to be edematous, one from handing and the other from dependency. In an older person this can make the difference between a benign recovery and death.

We do not wish to bring up difference in recurrences as a legitimate support for one approach or another. As stated before, the surgeon with a good knowledge of the anatomy of the diaphragm can only consider a recurrence as iatrogenic and unrelated to an inherent difference of the crura of the diaphragm as they are approached from above or below.

From an anatomic point of view, the crura of the diaphragm can be more easily approached from below the diaphragm. The crural margins act like a sling, the limbs of which originate from the lumbar vertebrae and extend cephalad to encircle the aorta and esophagus. This point makes these structures readily accessible from the abdomen.

Summary and Conclusions. A review of cases of esophageal hiatus hernia, personally observed, operated from below and above the diaphragm, is presented. In addition, several series of cases reported in the literature are analyzed.

Symptomatic esophageal hiatus hernia may present any or all the symptoms of any diseased portion of the alimentary tract. Symptomatic hiatus hernia has a definite relationship to symptomatic gastroduodenal ulcer. Associated alimentary tract disease is common to symptomatic hiatus hernia. For surgical therapy an approach from the abdomen permits a thorough exploration of the alimentary tract and treatment of the associated findings is best accomplished.

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REFERENCES

1. Brooks, J. R.: Hiatus hernia—the method of repair; a comparison of that done below the diaphragm with that done above, New Eng. J. Med. 266:233–237 (Feb) 1962.
2. Beretta, F. F. and Jordon, P., Jr.: Case of infradiaphragmatic repair of esophageal hiatal hernia, Surgery 42:1036–1042 (Dec) 1957.
3. Beardsley, J.M.: Esophageal hiatus hernia; repair from below, New Eng. J. Med. 254:409–412 (Mar 1) 1956.
4. Crawford, E. S. and DeBakey, M.D.: Abdominal repair of hiatal hernia; study of 138 cases, Am. Surgeon 24:889–895 (Dec) 1958.
5. Sprafka, J. L., Azad, M. and Baronofsky, I. D.: Fate of esophageal hiatus hernia; clinical and experimental study, Surgery 36:519–524 (Sept) 1954.

Herrington, J. L., Jr.: Hiatal hernia with esophagitis; treatment by hernia repair, vagotomy and pyloroplasty or antrectomy, Ann. Surg. 151:812–826 (June) 1960.

Jacobs, W. H. and Baronofsky, I. D.: Hiatal hernia repair, Am. J. Dig. Dis. 5:1039–1050 (Dec) 1960.

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Treatment of Undisplaced Carpal Navicular Fractures When Diagnosis Has Been Delayed

By GEORGE F. PRATT, M. D., Rhinelander, Wisconsin

■ THERE is general agreement that undisplaced fractures of the carpal navicular bone seen soon after injury are best treated by plaster immobilization. If these fractures are seen late and the question of nonunion arises, there is less agreement as to what constitutes proper management. Although no rigid rules can be applied, there is a large group of fractures diagnosed late that will heal with plaster immobilization.

Report of Cases. *Case 1.* A 17-year-old high school student consulted us because of a painful wrist which followed a football injury seven months previously. The injury had been considered a sprain because symptoms were mild.

Examination revealed a slight swelling of the wrist and tenderness on mild pressure over the snuffbox area. X-ray films of the wrist showed an ununited fracture of the waist of the left carpal scaphoid with cystic changes in the midpoint of the fracture line (Fig. 1).

A plaster cast was applied incorporating the wrist, the hand, and the thumb. At six-week intervals, the cast was removed for x-ray examination of the wrist. It was not until four months after the onset of treatment that the first signs of healing appeared, and not until one year after onset of treatment that healing was complete. During the period of immobilization, the patient worked in a grocery store and gas station and attended his gym classes in school. When evaluated two weeks after removal of the cast, there was no abnormality clinically or seen by x-ray films, and he has continued to be well.

Case 2. A 17-year-old high school student injured his right wrist playing football. He had pain following the injury but delayed seeking medical attention for 10 weeks. When first seen, x-ray films showed a fracture of the waist of the right carpal scaphoid (Fig. 2), with normal density of the fragments. A plaster cast was applied, and immobilization was carried out for five months, when the fracture was completely healed as revealed by x-ray films. One month later, almost full wrist motion was present, and the x-ray films showed normal findings. He has continued to be well.

Discussion. Delay in diagnosis may occur because symptoms are often surprisingly mild. An x-ray study may not be made or, if made, may not show evidence of a fracture at once. Indeed, the fracture line may not be visible for from 10 to 14 days.

These old fractures have been treated in a variety of ways including plaster immobilization alone, bone grafting with and without removal of the radial styloid, excision of part or all of the fractured scaphoid, wrist fusion, and no treatment at all. Some degree of permanent disability often follows surgical intervention.[1]

It is important, therefore, to select as many of these fractures as possible that will heal by plaster immobilization alone. Old fractures can be classified first as to time interval between injury and institution of treatment and, second, as to the x-ray appearance at the time of diagnosis. The time lapse between injury and onset of treatment beyond which union is impossible has not been established. It is probably true that the longer the delay, the more difficult it is to obtain union. Dickinson and Shannon[2] reported 5 cases with delays of two to nine months in which healing took place with conservative treatment. Bannerman[4] reported 16 cases with delays of one to four months with 100 per cent union. After six months delay, only 2 of 12 cases healed in plaster,

Presented at the fall meeting of the Wisconsin Surgical Society, Manitowish Waters, Sept. 13–14, 1963.

but we are not told how much time over six months had elapsed, how the fractures looked on x-ray studies, and how long immobilization was continued. Luxardo[5] (quoted by Mazet and Hohl) reported fractures 12 and 15 months old that healed by immobilization alone. Mazet and Hohl[6] reported 6 cases of their own with from 4 to 21 months delay in which healing occurred with immobilization alone.

Most authors pay more attention to the x-ray appearance of the fracture in determining prognosis than to the duration of delay in diagnosis. Any of the following details or combinations of details may be noted on the roentgenograph: (1) simple fracture line without displacement, (2) vacuolization or cystic change, (3) sclerosis along the fracture line, (4) avascular sclerosis of one or both fragments, and (5) arthritis.[3]

Watson–Jones[3] is very definite in the view that a linear fracture with or without cystic changes will heal with conservative treatment.

Sclerosis along the fracture margin is accepted as established nonunion and is, for the present, considered to be a contraindication to conservative treatment.[1-3] However, Stewart[7] noted that some of his freshly treated fractures developed sclerosis during treatment and then went on to heal with further immobilization. This puts a question mark behind the accepted view.

Avascular sclerosis of the proximal fragment which occurs especially in proximal pole fractures is generally considered an unfavorable condition for conservative management. However, revascularizations after conservative treatment have been reported by Dickinson and Shannon,[2] and Wagner,[8] making this a still somewhat controversial issue.

If these fractures are to be treated conservatively, it is necessary to have some idea of how long a period to continue immobilization. The reported results are generally so favorable when treated this way that reasonable persistence is worth the effort. Of five cases treated by Dickinson and Shannon,[2] union occurred in two to nine months. Luxardo's[5] two cases required six and seven months of immobilization. Bannerman's[4] 18 cases healed in four and one-half to seven and one-half months. Mazet's and Hohl's[6] six cases healed in 6 months to 22 months. London[9] reported 50 cases in which union oc-

Fig. 1—Case 1. Pasteraanteriar raentgenogram, after 7 months' delay in diagnosis, showing fracture of the scaphoid with cystic changes; seen in 11-year-ald boy.

Fig. 2—Case 2. Oblique raentgenagram, after 10 weeks' delay in diagnosis, shawing fracture af scaphoid bone; seen in 17-year-ald boy.

curred in up to 12 or more months, even though he sometimes removed the cast before x-ray evidence of union was present.

It is impossible to say what percentage of favorable cases will heal by immobilization alone after long delay because, as those reporting larger series emphasize, there are so many of the cases operated upon before an adequate trial of conservatism has been obtained.[2, 3, 6]

Summary. Two cases are reported in which fractures of the carpal scaphoid bone healed well with immobilization of 12 and 5 months, even though treatment was delayed for a long time. During the period of immobilization, the patients were able to carry on their work without serious inconvenience. There was no loss of function in the immobilized joints.

Other cases were reviewed from the literature in order to evaluate what group of these fractures might be expected to respond favorably to conservative treatment and how long immobilization should be continued.

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REFERENCES

1. DePalma, A. F.: Management of Fractures and Dislocations, Volume II, W. B. Saunders Co., Philadelphia, 1959, pp. 500–503.
2. Dickinson, J. C., and Shannon, J. G.: Fractures of carpal scaphoid in Canadian Army, Surg., Gynec. & Obst. 79:225–239 (Sept) 1944.
3. Watson-Jones, Sir Reginald: Fractures and Joint Injuries, The Williams & Wilkins Co., 1952, pp. 612–614.
4. Bannerman, M. M.: Fractures of carpal scaphoid bone: analysis of 66 cases, Arch. Surg. 53:164–168 (Aug) 1946.
5. Luxardo, J. C.: Quoted by Mazet and Hohl,[6] p. 88.
6. Mazet, Robert, Jr., and Hohl, Mason: Fractures of carpal navicu'ar: analysis of ninety-one cases and review of literature, J. Bone & Joint Surg. 45-A:82–112 (Jan) 1963.
7. Stewart, M. J.: Fractures of carpal navicular: report of 436 cases, J. Bone & Joint Surg. 36-A:998–1006 (Oct) 1954.
8. Wagner, C. J.: Fracture of carpal navicular, J. Bone & Joint Surg. 34-A:774–784 (Oct) 1952.
9. London, P. S.: Broken scaphoid bone: the case against pessimism, J. Bone & Joint Surg. [Brit.] 43-B:237–244 (May) 1961.

OBSTETRICAL BRIEF

OXYTOCICS: EMPLOYMENT AND SAFEGUARDS

By JOHN R. EVRARD, M. D., Milwaukee, Wisconsin

I. The use of oxytocics
- A. Antepartum
  - (1) Incomplete abortion
  - (2) Hydatid mole
  - (3) Missed abortion
- B. Intrapartum
  - (4) Induction of labor
  - (5) Uterine dysfunction
- C. Postpartum
  - (6) Postpartum hemorrhage due to atony

II. The intrapartum use is somewhat hazardous because of the ever-present danger of ruptured uterus. The contraindications of the use of dilute intravenous oxytocin (Pitocin) during the intrapartum period are:

- A. Polyhydramnios
- B. Multiple pregnancy
- C. Previous scar on uterus
- D. Over para IV

About five years ago, there were approximately 10 maternal deaths each year caused by the injudicious use of oxytocin. These deaths were associated with ruptured uteri and massive hemorrhage. Since that time, the Maternal Mortality Committee has recommended indications, contraindications and procedures to be followed when oxytocics are used before the completion of the second stage of labor. Cooperation has been good regarding these recommendations and at present the deaths caused by ruptured uteri have been reduced to approximately 3 or 4 per year. The fact that there still are maternal deaths from the misuse of oxytocics re-emphasizes the need for repeated discussion of this subject. Recently a new oxytocic called Tocosamine has been introduced into our armamentarium. Until more experience is reached with this particular drug, it should be subject to the same safeguards which we reserve for use of Pitocin.

The Division of Maternal and Child Welfare as well as the Committee on Maternal Mortality again would like to stress:

(1) Careful selection of patients for the use of oxytocics.

(2) The intravenous method is the safest method of using oxytocics.

(3) Constant attendance by the physician is necessary when this drug is used.

Presented at a conference on "Maternal Deaths—What Can We Do About Them?"; St. Catherine's Hospital Kenosha, Jan. 16, 1963; sponsored by the CES Foundation of the State Medical Society.

Experimental Wound Infection and Its Prevention by Topical and Parenteral Techniques

By RUEDI P. GINGRASS, M. D., A. STEPHEN CLOSE, M. D. and EDWIN H. ELLISON, M. D., Milwaukee, Wisconsin

■ DESPITE the advent of antibiotics, the problem of wound infection continues to plague the surgeon caring for clean as well as contaminated wounds. In this study a standard wound was contaminated with a measured inoculum, and various treatment techniques were used. The results are summarized and discussed.

Several recent experimental and clinical studies which contributed to the experimental design will be reviewed briefly. Miles[1-4] and Burke[5] have studied the early inflammatory changes that occur in bacterial lesions. Their work suggests that the initial three hours following inoculation of a wound is most important, with most bacteria being killed during this period by factors present in the blood stream. Parenteral antibiotics were most beneficial when given before or at the time of wound inoculation, and were of no value when given three or more hours after inoculation.

Singleton[6, 7] studied topical treatment techniques in wounds contaminated with homogenized feces. In work with irrigating solutions he found that a solution of 1 per cent neomycin was most effective. Scrubbing of the wounds with various soaps also decreased the incidence of infection.

Most clinical studies[8-10] of parenteral antibiotics have concluded that "prophylactic" antibiotics do not diminish the incidence of postoperative infection. However, almost all these studies have begun antibiotic therapy postoperatively and with drugs with a relatively limited spectrum of activity. A few studies [11, 12] do suggest that antibiotics begun preoperatively are of significant value. Our study sought to confirm this and also verify the previous work done with topical techniques of treatment. In addition, we combined parenteral and topical techniques of treatment in some groups. Finally, we felt that a carefully standardized inoculum is of paramount importance in this type of work and had usually not been used by previous experimenters.

Description. Guinea pigs weighing 500–800 Gm. were anesthetized with intraperitoneal pentobarbital sodium (Nembutal). The skin was prepared by clipping, depilation (Nair), and spraying with PVP–I (Betadine). Standard incisions 3 cm. in length were made in the interscapular region using aseptic technique. The wounds were inoculated with 0.2 ml. of a suspension of *Staphylococcus aureus*, phage type 80/81. A 24-hour broth culture was centrifuged, resuspended in saline solution, and diluted to give approximately 40 million organisms per milliliter. Multiple plate counts were done to determine the number of viable organisms inoculated per wound, with results showing a range between 4.6 and 8 million organisms. One hour after incision and inoculation, the wounds were treated and sutured. Those in the control group were not treated. The wounds were then observed for the development of infection, as manifested by induration. Multiple wounds were cultured, with almost complete correlation between the presence of induration and positive cultures of *S. aureus*. The techniques used and the results in the various groups are reported together.

Results. The groups are listed under four categories: (1) controls, (2) topical treatment, (3) parenteral treatment, and (4) combination—topical and parenteral—treatment.

Doctor Gingrass presented this prize-winning resident paper at the fall meeting of the Wisconsin Surgical Society, Manitowish Waters, Sept. 13–14, 1963. Doctor Gingrass was a resident at the Veterans Administration Hospital, Wood. He is presently a resident in plastic surgery at Duke University Medical Center, Durham, N. C.

Controls: (1) Not inoculated. Wounds were made but not inoculated. No infection was noted in 20 animals.

(2) Inoculated, not treated. Wounds were inoculated but not treated, with infection present in all 39 wounds.

Topical Treatment: (1) Saline solution irrigation. Wounds were irrigated with 100 ml. of sterile saline solution, and all 10 wounds were infected.

(2) Saline solution scrub + saline solution irrigation. The wounds were scrubbed for one minute with cotton balls soaked in saline solution, and were then irrigated. All 10 wounds so treated were infected.

(3) Hexachlorophene (pHisoHex) scrub + saline solution irrigation. The cotton balls used for scrubbing were soaked in hexachlorophene with scrubbing followed by saline solution irrigation. Twenty animals were studied and all 20 were infected.

(4) Hexachlorophene scrub + neomycin solution irrigation. After scrubbing, a 0.5% solution of neomycin was used for irrigation. Twelve of 20 wounds became infected.

(5) Neomycin instillation. Neomycin solution was used to fill the wound for two minutes prior to inoculation. All 20 wounds were infected. When instilled for five minutes an hour after inoculation, one wound did not become infected in 20 animals so treated.

(6) Neomycin irrigation. Wounds were irrigated with 50 ml. of 0.5% solution of neomycin, with 25 infections in 30 wounds.

(7) Neomycin scrub + neomycin solution irrigation. Forty animals were studied, with 16 infections resulting.

Parenteral Treatment: Neomycin was given intramuscularly in a dose of 10 mg. per kg. Five different techniques of treatment were used. All animals in each group became infected, and the number is included after each technique.

(1) Neomycin 1 hour preoperatively (before incision and inoculation) —10.

(2) Neomycin 1 hour postoperatively (after incision and inoculation) —10.

(3) Neomycin 1 hour postoperatively + twice a day for 2 days—10.

(4) Neomycin 3 hours postoperatively + twice a day for 2 days—10.

(5) Neomycin 1 hour preoperatively + 1 hour postoperatively + twice a day for 2 days—15.

Combination Treatment: Animals in this category were given a combination of topical and parenteral treatment.

(1) Hexachlorophene scrub + neomycin solution irrigation + preoperative parenteral neomycin. Ten animals were so treated, with four infections.

(2) Hexachlorophene scrub + neomycin solution irrigation + postoperative parenteral neomycin. Eight of 10 wounds became infected.

(3) Hexachlorophene scrub + neomycin solution irrigation + preoperative, postoperative, and twice a day for two days parenteral neomycin. Two of 10 wounds were infected.

(4) Neomycin scrub + neomycin solution irrigation + postoperative and twice a day for two days parenteral neomycin. Thirty animals were given neomycin intramuscularly one hour after closure, and 30 intramuscular injections of neomycin three hours after closure. There were four infections in each group.

(5) Neomycin scrub + neomycin solution irrigation + preoperative, postoperative, and twice a day for two days parenteral neomycin. There were 5 infections in 30 animals so treated.

Discussion. This experiment attempted to standardize the quantity of viable organisms that were used for inoculation of contaminated wounds. A range of 4.6 to 8 million organisms per wound was calculated, in contrast with most previous similar experiments in which no attempt was made to determine this, or in which a much wider range was estimated. Condie and Ferguson[13] stated that a range of 80 to 800 million organisms was used in their experiment.

With our techniques, topical methods which proved worthless included saline solution irrigation, saline solution scrubbing, hexachlorophene scrubbing, and neomycin instillation. Neomycin solution was of limited value with irrigation alone, but produced a significant reduction in the incidence of infection when utilized after gentle scrubbing of the wound.

Parenteral neomycin was of no value when used alone. However, it did yield a significant further decrease in infection when administered for three days and combined with the most effective topical methods. It should be noted that the initial dose was administered preoperatively or within three hours postoperatively.

A rationale for our experimental results can be formulated. Scrubbing and irrigation with saline solution undoubtedly resulted in a reduction of the number of inoculated organisms, but not below the critical level at which a sufficient number remained to produce infection in all wounds. Use of neomycin solution caused a greater decrease, by killing some organisms remaining after irrigation, and this brought the number remaining below the critical level in some wounds. Addition of parenteral neomycin to the topical technique decreased the number of organisms in the wound still further, and thus significantly decreased the number of infected wounds.

No clinical comparisons can be made on the basis of our work, in which the only really significant variable was use of a measured inoculum of bacteria. Many other factors that play a role in the development of infection in operative wounds in patients were either not present or were comparatively controlled. This study should help point out the need for carefully controlled clinical and experimental studies of the problem of wound infection. Neither the experimental nor the clinical literature convincingly demonstrates that "prophylactic" antibiotics, particularly when used topically, do not prevent some wound infections.

Summary. Gentle scrubbing and irrigation with neomycin solution were of significant benefit in preventing infection in contaminated wounds. Parenteral neomycin, when administration was started preoperatively or within three hours postoperatively and continued for two days, was of definite additional value when combined with topical treatment. A measured inoculum was used. The validity of previous work in which a variation in the inoculum was permitted is questioned.

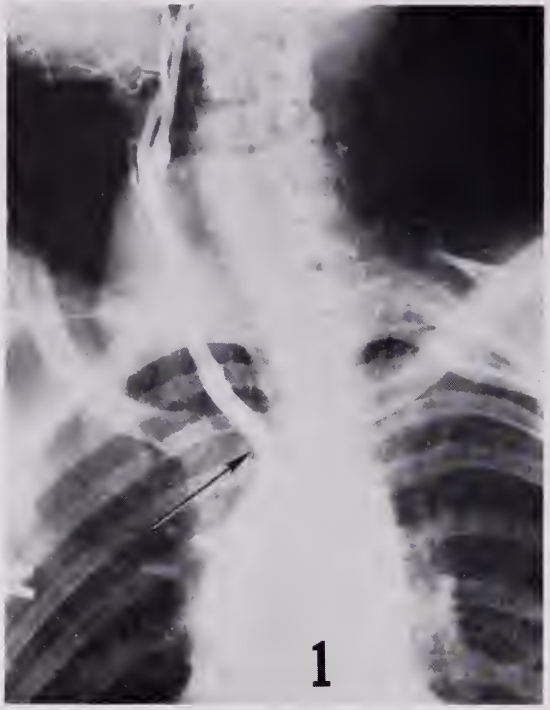
(R.P.G.) 2014 Dartmouth Drive, Durham, N. C.

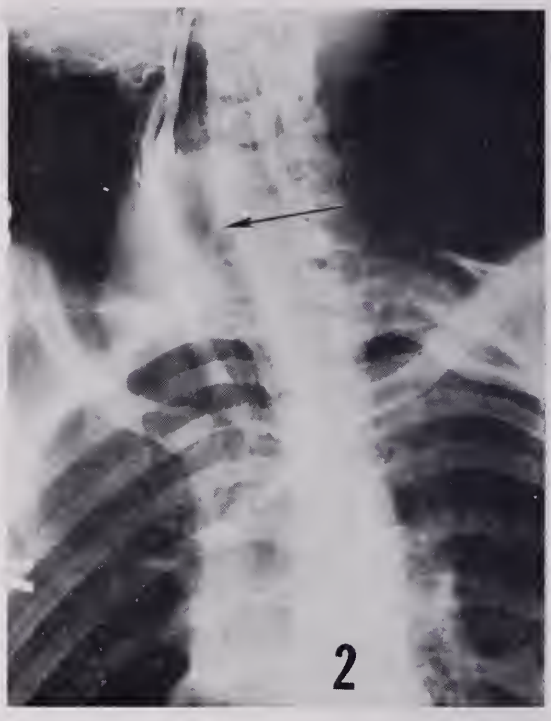
REFERENCES

1. Evans, D. G., Miles, A. A., and Niven, J. S. F.: Enhancement of bacterial infections by adrenaline, Brit. J. Exper. Path. 29:20–39 (Feb) 1948.
2. Miles, A. A., and Niven, J. S. F.: Enhancement of infection during shock produced by bacterial toxins and other agents, Brit. J. Exper. Path. 31:73–95 (Feb) 1950.
3. Miles, A. A.: Nonspecific defense reactions in bacterial infections, Ann. N. Y. Acad. Sci. 66:356, 1956.
4. Miles, A. A., Miles, E. M., and Burke, J.: Value and duration of defense reactions of skin to primary lodgment of bacteria, Brit. J. Exper. Path. 38:79, 1957.
5. Burke, J. F.: Effective period of preventive antibiotic action in experimental incisions and dermal lesions, Surgery 50:161–168 (July) 1961.
6. Singleton, A. O., Jr., Davis, D., and Julian J.: Prevention of wound infection following contamination with colon organisms, Surg. Gynec. & Obst. 108: 389–392 (Apr) 1959.
7. Singleton, A. O., Jr., and Julian, J.: Experimental evaluation of methods used to prevent infection in wounds which have been contaminated with feces, Ann. Surg. 151:912–916 (June) 1960.
8. Barnes, J., Pace, W. G., Trump, D. S., and Ellison, E. H.: Prophylactic postoperative antibiotics, a controlled study of 1,007 cases, Arch. Surg. 79:190–196. (Aug) 1959.
9. Sanchez–Ubeda, R., Fernand, E., and Rousselot, L. M.: Complication rate in general surgical cases, the value of penicillin and streptomycin as postoperative prophylaxis: a study of 571 cases, New Eng. J. Med. 259:1045–1050 (Nov 27) 1958.
10. Tachdjian, M. O. and Compere, E. L.: Postoperative wound infections in orthopedic surgery, evaluation of prophylactic antibiotics, J. Internal. Coll. Surgeons 28: 797–805 (Dec) 1957.
11. Alexander, J. W., McGloin, J. J., and Altemeier, W. A.: Penicillin prophylaxis in experimental wound infections, Surgical Forum, p. 299, 1960.
12. Spencer, F.: In discussion of paper by Burke.[5]
13. Condie, J. D. and Ferguson, D. J.: Experimental wound infections: contamination versus surgical technique, Surgery 50:367–371 (Aug) 1961.

PAMPHLETS AVAILABLE ON HANDICAPPED CHILDREN

Three publications, two designed to promote understanding of the needs of children with brain injuries and one to contribute to understanding of children handicapped by aphasia, are available from the National Society of Crippled Children and Adults. The titles are: The Brain Injured Child in the Classroom, by Newell C. Kephart, Ph.D. (Purdue University); Discovering, Evaluating, Programming for the Neurologically Handicapped Child with Special Attention to the Child with Minimal Brain Damage, by Charles R. Strother, Ph.D. (University of Washington); and Childhood Aphasia, by 28 specialists who participated in an Easter Seal Research Foundation institute. Copies of the first two titles (No. E-34 and E-35, respectively) are 35 cents each. The third title is $1.00 a copy. Requests should be addressed to Publications Office, National Society for Crippled Children and Adults, 2023 West Ogden Avenue, Chicago 12, Ill.





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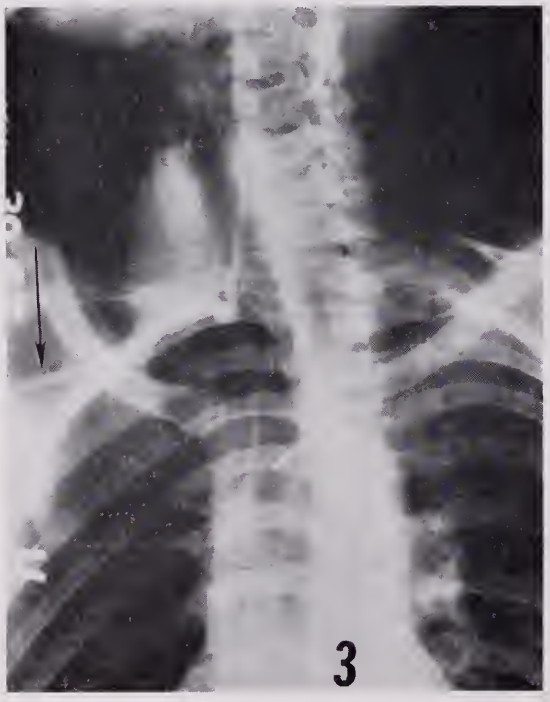

Fig. 1—There is visualization of the innominate artery (arrow), and the left common carotid at its take off. The right common carotid is seen dividing into the internal and external carotid. Note that at this time there is no filling of the right subclavian or the right vertebral arteries.

Fig. 2—The contrast material that entered the cranial vault via the internal carotid now is seen returning to the neck in the vertebral artery (arrow). On the left side the carotid and subclavian arteries are seen.

Fig. 3—The right vertebral is filled as is the right subclavian. The right subclavian therefore does not fill via the aorta but is totally dependent for its blood supply on the cerebral circulation via the vertebral artery. Endarterectomy was successful in reestablishing normal flow from the innominate artery to the subclavian.

A 39-year-old white woman was admitted to the hospital because of heaviness and numbness of the right upper extremity. This phenomenon had recurred on numerous occasions during the previous year. Usually this was of very brief duration. At the time of the physical examination a marked weakness of the right radial and brachial artery pulses was found. Blood pressure in the right arm was 90/70 and in the left arm 140/80. Neurological findings were within normal limits. A catheter was placed in the aortic arch and radiopaque material injected.

Prepared by Daniel J. Price, M. D., resident in radiology at Milwaukee County Hospital, under direction of John R. Amberg, M. D., radiologist, Department of Radiology at Milwaukee County Hospital.

ANSWER on page 510

Present Day Treatment of Dupuytren's Disease

By WILLIAM H. FRACKELTON, M. D. and JACK L. TEASLEY, M. D.
Milwaukee, Wisconsin

■ **WHAT IS Dupuytren's disease?** It is *nodular* and *contractural* involvement of the palmar fascia and its digital extensions.

The *palmar aponeurosis* arises from the palmaris tongus tendon and/or the anterior wrist fascia. Its longitudinal fibres extend distally and in a fanwise pattern. Transverse fibres are present especially near the finger webs. Multiple septa extend longitudinally and in depth to be anchored at the deep palmar fascia to the sides of the metacarpals. Eight tunnels are thus formed, four containing neurovascular and lumbrical muscle structures, and four the long flexor tendons. The *digital extensions* surround nerves and vessels and are anchored to the phalanges. Shrinkage of these extensions leads to digital joint contractures.

The *pathological involvement* is limited to the palmar fascia and its extensions and does not directly affect tendon, nerve, or muscle. Nodules of fibrous connective tissue form, and adjacent cord-like fascial hypertrophy and contracture follow.

The *etiology* is indeterminate. Familial tendency is the most frequent factor. Inflammation, proliferation—neoplasia, and trauma have been considered etiologically, but not definitively confirmed.

What is the incidence of Dupuytren's disease? It is in 1.2 to 2.0 per cent of the general population. It occurs 7 times more frequently in males than females. The disease manifests itself most frequently in the fourth to sixth decade of life. It is bilateral in over 50 per cent of the cases. Most frequently it occurs first near the bases of ring, little, and mid finger—in that order. It is common in nonmanual as well as manual workers. It is rare in African and Oriental races.

Summary of paper presented before the Wisconsin Surgical Society at the 122nd Annual Meeting of the State Medical Society of Wisconsin, May 9, 1963, Milwaukee.

How is the diagnosis of Dupuytren's disease made? *Palmar nodulation,* often with "dimpling" of the skin (due to contracture of fine strands of connective tissue anchoring the palmar skin to the palmar fascia), and subsequently with *flexion contracture* of the proximal and mid joints *of involved fingers.* Differentially to be considered are: tumor, congenital contracture of little finger, joint stiffness following infection or injury, and contracture due to surface burns or scars.

What associated involvement is found in Dupuytren's disease? In addition to palmar fascia involvement there may be an identical process in plantar fascia, knuckle pads on the extensor surfaces of fingers may be present, Peyronie's disease is occasionally present.

What is the treatment of Dupuytren's disease? The treatment is *operative.* Nonoperative use of x-ray; injections—e.g., cortisone, vitamin E; and stretch splinting do not cure nor prevent progress of the process.

The operative treatment is:

(a) *Fasciotomy*—The "open" method of transverse incision was originally tried and no longer is used. Subcutaneous fasciotomy is applicable to palmar involvement, not digital.

(b) *Partial fasciectomy*—Aims at removal of involved fascia only. It is usually followed by more rapid healing and regaining of mobility than—

(c) *Total fasciectomy* of the palmar portion and involved extensions into the fingers is suitable for medium aged adults without tendency to stiffness or rheumatism, and who are handicapped in their activities by the contracture.

What is the postoperative treatment? *Immobilization* without excessive stretching or pressure—by splint or cast—is used during immediate healing. *Mobilization* of the hand by

active motion is begun when the skin areas are healed. Elastic splints are used after skin healing for further stretching of joints.

What are postoperative complications and how are they counteracted? *Hematoma* is prevented by hemostasis control at operation and by routine drainage of the operative incision in the palm.

Ischemia is avoided by careful dressing without excessive pressure.

Skin loss is treated by replacement of "poor" areas by skin grafts or pedicles at the time of operation, and by excision of necrotic areas and skin grafting postoperatively.

Joint stiffness is counteracted by elevation of arm, active movement, no passive forcing of joints, and systemic cortisone in some cases. People with high endomorphic constitutional index tend to joint stiffness; they should have operations of the limited type.

Recurrence cannot be prevented, for surgery removes existing involvement but not the tendency nor the progression in residual areas. Thus areas of palmar fascia not involved at the time of operation may later show nodulation and contracture.

What are the results of operative treatment? Progression of the contracture is counteracted, and in the majority it is relieved to a beneficial degree.

OBSTETRICAL BRIEF

CATASTROPHY OF THE ABRUPTIO PLACENTA

By FREDERICK J. HOFMEISTER, M. D., Milwaukee, Wisconsin

Bleeding during the third trimester must direct the physician's attention to:

I. Placenta Praevia
   A. Incidence quoted as being between 1 per 100 and 1 per 200 deliveries.
   B. Found most often in multipara.
   C. A history of past uterine trauma or inflammation may exist.
   D. Bleeding varies from spotting to profuse bleeding.
   E. First bleeding episode is usually self limiting and a "signal bleed."
   F. Bleeding without pain.
   G. Uterus soft; abdomen not tender.
   H. If tender, there are periods of rest and relaxation.
   I. Diagnosis primarily by sterile vaginal examination in operating room. All safeguards are necessary. Conditions of vaginitis, erosions, polypi and carcinoma must have been eliminated by accurate prenatal care.
   J. Secondary method, soft tissue visualization and visualization by contrast media.

II. Abruptio Placenta, Our Concern
   A. Incidence found in 1,049,782 deliveries, or 1 in 120 deliveries.
   B. Found in multipara and associated with:
      (1) Toxemia.
      (2) Hypertensive cardiac and renal disease.
      (3) Short cord.
      (4) Trauma.
      (5) Sudden decompression from rupture of membranes. (Toxemia and hypertensive cardiac disease are of prime importance.)
   C. Bleeding may vary from moderate to excessive.
   D. Abdominal tenderness and tenseness will vary from a state of irritability to boardlike rigidity.
   E. Fetal heart tone present in mild states and absent in the severe.
   F. Shock will vary with degree of irritability.
   G. Presence of hypofibrinogenemia will vary with the degree of shock, the degree of uterine irritability, and the existence of fetal death.
   H. The diagnosis is made by vaginal examination in an operating room setup under sterile conditions in addition to the history.
   I. Treatment
      (1) Available fluid
      (2) Available blood
      (3) Available fibrinogen
      (4) *Most important*—ACTION
         (a) If the patient is in labor and a multipara with a widely dilated cervix — RUPTURE THE MEMBRANES.
         (b) If the patient is a primipara with or without dilatation, or multipara in early labor with minimal dilatation—CAESAREAN SECTION.
         (c) When complications are compounded when the sectioned uterus does not contract—HYSTERECTOMY with METICULOUS CONTROL OF BLEEDING IS ESSENTIAL.

It must be remembered that the most conservative approach may be the most radical.

Presented at a conference on "Maternal Deaths—What Can We Do About Them?"; St. Catherine's Hospital, Kenosha, Jan. 16, 1963; sponsored by the CES Foundation of the State Medical Society.

CLINICOPATHOLOGIC CONFERENCE

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C

Sponsored by the Section on Pathology, State Medical Society of Wisconsin

Guest Editor: L. W. KLEPPE, M. D.
Beloit, Wisconsin

Case Presentation.* This 46-year-old deaf-mute woman was readmitted to the hospital after having been discharged one week before. Her first admission was for low abdominal pain of 12 hours duration. At this time the physical findings were limited to the lower abdomen and pelvis. She had tenderness to palpation in both lower quadrants, over both adnexae and on movement of the cervix. There was no discharge from the cervix. Although evaluation was difficult, we believed that the patient had a pelvic inflammatory disease. She was afebrile throughout her admission and she was treated with antibiotics, including penicillin, streptomycin and, because of failure to respond promptly, chloramphenicol. Her symptoms cleared slowly.

She was discharged on the sixth hospital day, feeling better. Her white blood cell count on her first admission was approximately 20,000 with a shift to the left. This returned to normal under treatment. After her discharge from the hospital, she felt fairly well for one day, and then she began to have a great deal of abdominal distention and persistent vomiting. She did not complain of pain in the lower abdomen. These findings were present intermittently for approximately five days; then the vomiting became persistent and she was unable to retain any food. She was readmitted to the hospital.

Her family history was noncontributory except that her husband and two children are also deaf mutes. Her past history revealed an appendectomy many years ago; Cesarean section and tubal ligation 10 years ago. No significant medical diseases were noted.

On admission, physical examination showed blood pressure 96/52, temperature 99.4 F., pulse 88, respirations 20. The patient appeared acutely ill. Positive physical findings limited to the abdomen demonstrated some moderate distention with generalized abdominal tenderness of a moderate degree. Intestinal sounds were hyperactive.

On admission, laboratory studies showed a white blood cell count of 10,700 with a normal differential; hemoglobin level, 14.6 Gm. per 100 ml.; serum sodium, 140 mEq.; serum potassium 4.5 mEq.; serum chloride, 98 mEq./l.; carbon dioxide, 26 mM./l.; pH 7.41; urine 4 + acetone, otherwise normal. The gallbladder was not visualized with cholecystography. Examination of the abdomen revealed dilated small and large intestine with fluid level formation. A small amount of barium oraly administered indicated only that small bowel dilatation was confined to the distal ileum. Dilatation of the colon extended to the sigmoid. A few films suggested air within the biliary tract and the presence of peritoneal fluid.

A probable diagnosis of obstruction of the sigmoid colon was made. The differential diagnosis was malignancy, diverticulitis, or gallstone ileus. With barium enema, an obstruction was seen in the proximal sigmoid colon, although the margin of the obstruction was not well outlined. The sigmoid obstruction was partially relieved upon turning the patient into a prone position, and for this reason a diagnosis of extrinsic pressure obstruction was considered.

The patient was treated intravenously with fluids and continuous suction; however, the distention and apparent obstruction were not relieved, and on the fourth hospital day she was taken to surgery. Before surgery her serum electrolytes were essentially unchanged. The white blood cell count was 9,250. The hemoglobin level was unchanged. At surgery an obstructing lesion was found in the sigmoid colon. There was a firm nodular area with a considerable peritoneal reaction and matting of the omentum. The lesion was believed to be malignant. A colostomy was performed.

* From the Beloit Hospital, Beloit.

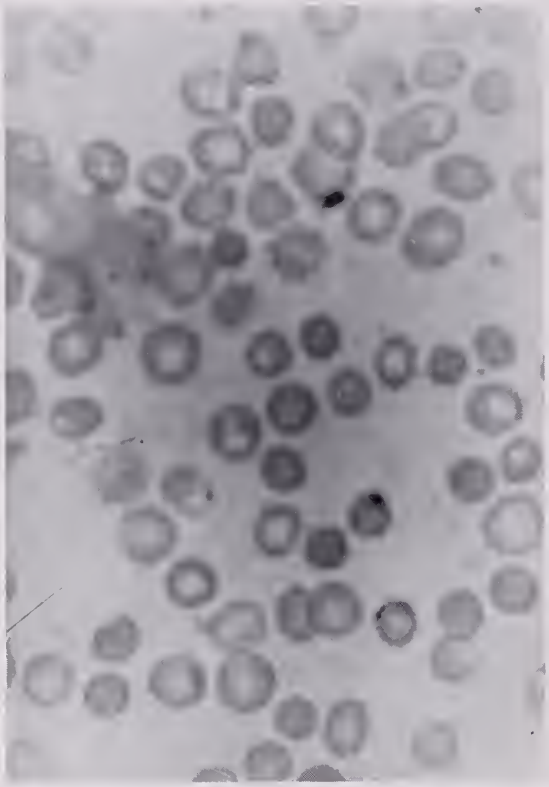

Fig. 1—Postmortem blood smeor showing spherocytosis.

The patient tolerated surgery fairly well; however, her blood pressure was noted to drop on several occasions and methamphetamine hydrochloride (Methedrine) was injected on two occasions. She was returned to the recovery room in good condition. On the evening following surgery her pulse was noted to have risen from an immediate postoperative level of 96 to 140. Her blood pressure was 100/70, which was essentially what it had been all day. Administration of digitoxin was begun at that time. The pulse remained elevated.

Approximately 20 hours after surgery her blood pressure fell to 82/58. Phenylephrine hydrochloride (Neo-synephrine) was administered. The pulse at that time was 128. Throughout the second postoperative day her blood pressure remained in the range of 80/60 and her pulse approximately 120 to 140. At 10 p.m. on the second postoperative day her blood pressure fell to 70/46 and the pulse rose to 152. Oxygen was started at that time. The patient was given 1.0 ml. of methamphetamine hydrochloride. During this period the patient was apparently experiencing no pain, and repeated examinations revealed no evidence of hemorrhage. Serum electrolytes were obtained: sodium, 124 mEq.; potassium, 5.3 mEq.; chloride, 90 mEq. The hemoglobin level was 14.6 Gm. per 100 ml. with a hematocrit reading of 49%. Because of failure of the blood pressure to respond to the above treatment, *l*-norepinephrine (Levophed) 1 ampule in 1,000 ml. of 5% glucose in water, was begun and the blood pressure was maintained at about 90 to 110 for several hours. It again began to drop. The pulse became so rapid that it was unobtainable at the wrist but the apical rate was found to be approximately 180 to 190. Digitalization was completed without effect. Hypertonic saline solution was administered slowly and 200 ml. were given. This did not affect the rapid rate. The *l*-norepinephrine was administered more rapidly and the blood pressure was obtained at approximately 90/50 until on the third day, 48 hours after surgery, when it became unobtainable. Apical rate at this time was approximately 180 to 190. This was verified by an electrocardiogram. Consultation was obtained and decision was made to give quinidine intravenously with electrocardiographic control. A dramatic response was noted in rate, and the pulse fell to approximately 100. The blood pressure and radial pulse were still unobtainable. The patient received steroids intravenously. There had been a question of jaundice noted 12 hours prior to this, and at this time she was found to be definitely jaundiced. The jaundice was noted to progress rapidly and became marked over a several-hour period. She received 1,000 ml. of whole blood without any apparent improvement in her general condition. Because the pulse rate again rose to the original level, quinidine was repeated intravenously with a good response which lasted for approximately an hour. In spite of this, her general condition deteriorated and she died approximately 56 hours after surgery.

Discussion. *Dr. K. L. Carter:* Review of the protocol on this patient reveals that she had an inflammatory mass present in the lower abdomen which responded slowly to antibiotics but from which she was apparently making a satisfactory recovery when she was discharged from the hospital on her first admission. Upon her second admission, we were told that she had a return of her

pain shortly after being discharged from the hospital, that her pain was intermittent in character and that there was a persistent vomiting which had established itself before her readmission.

It is to be noted on readmission that her blood chemistry studies were not significantly altered except for a slightly decreased serum chloride of 98 mEq. and a 4+ acetone, both of which could be readily explained by her persistent vomiting. Preoperative radiographic studies of the abdomen revealed dilated sigmoid obstruction. There is no mention made of a sigmoidoscopic examination. On her fourth hospital day, she was taken to surgery where there is a report of a firm nodular area with considerable peritoneal reaction and matting of the omentum. No mention is made of any metastatic disease. No attempt at biopsy or resection was made and a proximal colostomy was done. From the protocol, it would appear that her immediate postoperative condition and progress was satisfactory for the first 12 hours, at which time a tachycardia was noted. At about the 20-hour postoperative period, she manifested a drop in blood pressure to 82/58. A hypotension is recorded for the second postoperative day; and at 36 hours postoperatively, there was a hyponatremia of 124 mEq. and a hypochloremia of 90 mEq. A vasopressor was added to the intravenous fluids, as was hypertonic sodium chloride. On the third postoperative day, the blood pressure and pulse were unobtainable and jaundice was noted. She was well into irreversible shock and died approximately 56 hours after surgery.

We are dealing with a case of postoperative shock. The type of shock to be considered in this discussion does not include the shock that occurs during surgery nor the shock that occurs in the immediate postoperative period, i.e., the 3 to 4 hours usually spent in the recovery room. It was not until about 20 hours after surgery that hypotension was demonstrated. We must consider at this time the hypotension, secondary to hemorrhage or to excessive drainage of a serosanguineous nature, which depletes the blood volume. In this instance there was no evidence of intra-abdominal or wound hemorrhage. Postoperative pancreatitis with fluid loss into the peritoneal cavity and peripheral vascular collapse is a consideration. This patient evidently had no upper abdominal or back pain, but a serum amylase was not reported. Massive fluid loss in cases of peritonitis is usually associated with a rising hematocrit reading. This fluid can be lost into the intestine, peritoneal cavity, or even into the retroperitoneal space.

Dr. D. M. Clark: The serum amylase was reported as normal, and the patient was never febrile.

Doctor Carter: Another frequent cause of hypotension is the result of inadequate pulmonary function. There is nothing in the protocol to suggest atelectasis.

Several basically vascular lesions should be considered. Our first thought here is that of a cerebral vascular accident as precipitating the hypotension. We have no indication of development of hemiplegia or other sign of increased intracranial pressure. Another common cause of postoperative shock is myocardial infarction. Here we have an electrocardiographic report of no myocardial infarction. Enzyme studies available are of little help after operative muscle trauma. A pulmonary embolus must be considered, but there is little to make one suspect such an occurrence here.

Adrenal cortical failure most often occurs 10, 12 or even 18 hours after surgery has been completed. The cardinal clinical findings are hypotension, tachycardia, hyperthermia, and apprehension, followed later by disorientation and coma.

The last major heading to be considered is that of infection and endotoxin shock. The possibility of bacterial invasion with septicemia and circulatory collapse should always be considered at this point in the postoperative period. Usually this is ushered in by a sudden chill, hyperthermia, rapid pulse, hypotension and a generalized toxicity. The manner in which the endotoxin produces shock is not completely understood. There is evidence that it acts upon the myocardium to diminish the force of myocardial contraction. Added to this, there is the increased loss of fluid into the peritoneal cavity and intestine, producing a hypovolemic type of shock with the superimposed toxicity of the endotoxin. The normal temperature is not a great comfort.

In summary, this case presents a patient who developed hypotension approximately 20 hours after surgery. This hypotension was severe and progressive in spite of supporting therapy, including blood, intravenous fluids, and vasopressors. It would appear as though this patient experienced a hypovolemic type of shock which could be most readily explained on the basis of infection and endotoxin shock.

Dr. L. W. Kleppe: Doctor Carter arrived at the same diagnosis that the attending physicians had been considering. This diagnosis was essentially correct except that one additional determination gave a great deal more information. Because of the rapidly developing jaundice, a postmortem peripheral blood smear was examined. This smear, as can be seen in Figure 1, demonstrated considerable numbers of microspherocytes. In view of lack of spherocytosis on initial examination, *Clostridium* toxemia was immediately considered.

A large, deep, wound abscess was encountered as the examination progressed. The tissues here were edematous, necrotic, and fetid. *Cl. welchii* and *Escherichia coli* were cultured from the abscess.

An adenocarcinoma of the sigmoid colon was present and associated with considerable local peritoneal reaction. No area of perforation could be identified.

The source of the organisms causing this patient's difficulties is problematical. Certainly the intestine is a rich source of both. Clostridia are not an infrequent wound contaminant if anaerobic cultures are routinely done. Fortunately the spores seldom find good anaerobic conditions under which to mature. It appears that an accompanying agent such as *E. coli, Proteus* or *Staphylococcus* is necessary or at least beneficial to their maturation and proliferation.

One of the exotoxins of the Clostridia, probably lecithinase, causes impairment of cell membrane metabolism and the spherocytosis. The peripheral vascular collapse is characteristic.

Final Diagnosis. The final diagnosis was (1) wound abscess containing *Cl. welchii* and *E. coli*, with acute hemolytic anemia, *Clostridium* toxemia, generalized vasoparalysis, and moderate myocardial edema; and (2) adenocarcinoma of the sigmoid colon.

ROENTGEN RIDDLE

continued from page 504

ANSWER

The diagnosis is "subclavian steal." The opaque material was injected into the mid ascending aorta.

Patients with these syndromes may present with a variety of complaints, usually with brief episodes of confusion, monocular blindness, headache, or a "small stroke syndrome." After the seizure there is as a rule no neurologic residual.

On physical findings hemicranial bruits are heard on the involved side. There is also decreased blood pressure, and absence of radial pulse, and occasionally a subclavian thrill on the involved side.

This phenomena results from any occlusive vascular disease between the origin of the subclavian artery and the origin of its vertebral branch. It may occur on either side of the body.

One of three cases presented in an article entitled "Subclavian Steal" by Doctor Price in *GP*, July 1963, pp. 112–117.

HOW MUCH FOR DRUG RESEARCH IN 1970?

I am very happy to see that the pharmaceutical industry . . . research spending on medical products for human use is five times greater than it was some 11 years ago. It went from $50 million in 1951 to approximately $250 million in 1962. Each year the drug industry tests more than 100,000 substances which may yield only about 40 marketable compounds. For every new drug that reaches the public the industry has spent some $6 million in research and development cost. Estimates of industry expenditures for research by 1970 are between $400 million and $500 million annually. New and better miracle drugs are bound to be developed for the aid of mankind.—HON. OREN HARRIS, *Chairman*, House Commitee on Interstate and Foreign Commerce, to Pharmaceutical Advertising Club, New York City, April 11, 1963.

PUBLIC HEALTH NURSING: A FAMILY-CENTERED SERVICE

AS MEDICAL care becomes more specialized, nursing care is tending to be less compartmentalized. Traditionally, public health nursing has spoken of itself as a "family health service." In actual practice this has not always been evidenced, probably because of our failure to interpret to communities the manner in which we can make our most effective contribution. Citizens and other professions tend to see us in the role they visualize as "nurse," or in the one their experience with public health nurses dictates. Thus, the physician is apt to picture her as the one who is filling the syringe at an immunization center or giving Mrs. Jones her Vitamin B_{12} once a week; the mother often expresses her image of the public health nurse when she asks, "what do you do now that school is out?"

The public health nurse has a unique contribution to make since she is often the only community worker in a position to promote family health and to bring the family in distress to the resources for diagnosis and treatment. Through family-centered health service, the public health nurse is developing a modern concept of prevention and control. She often sees the family without a crisis, before trouble arises. In the normal course of a day's work she meets families at a time when life situations causing varying degrees of stress can be anticipated—birth, school entrance, adolescence, marriage, parenthood, illness and aging. She can assist the family in applying scientific knowledge about health, about growth and development, and hopefully, help them to recognize and meet their needs.[1]

Why all of this emphasis on the family, you may ask, when we know that illness occurs in the individual, as do the problems and stress we have enumerated as resulting from growth and development? The causative factors of many disorders lie within the family itself. Simple examples may occur to us, as the family with a long history of diabetes or tuberculosis. More complicated, but seemingly an established fact, is the effect of an emotional crisis of the antepartum patient upon the development of her child.[2] Knowledge of the strength or weakness of emotional ties within a family may throw considerable light on the behavioral patterns of a school child. Does this individual cherish his illness as a legitimate escape from the responsibilities of life rather than a condition from which to recover?

In many instances family cooperation and understanding are essential to prevention or treatment. The diabetic patient must consider her diet in the context of the eating habits of her whole family. Have you noted that some families can give sustained care to the complaining long-term patient with safety and at least a degree of comfort and satisfaction? In other families the same situation may demand a great deal of medical and nursing support because of resentment and frustration. Then there is the family that refuses to allow the long-term patient to be rehabilitated because of its own needs, whatever they may be.

The public health nurse is in an advantageous position to observe all needs of the family. Seldom do we find illness an isolated problem. Of course, she will use all her skills to bring the family to medical care if this is indicated and has not been obtained; she will call to the physician's attention special resources available to him of which he is not aware or which his community does not provide. Because of her knowledge of the family she will also help the school understand a child's behavior in terms not of an isolated individual, but as a member of a family with its own strengths and weaknesses; she may discuss family counseling with a minister; or seek special help from the vocational rehabilitation worker, economic assistance from a welfare agency, or recreational diversion from a youth counselor. She is not expert in social diagnosis, but as a family-centered worker she is in a position to coordinate and provide continuity to the needs of families.

"The home visit is the traditional approach of public health nursing service and remains one of the most frequently used and highly regarded methods of providing service."[3] While there are other methods, all with certain advantages and disadvantages, the outstanding merits of home visiting must be obvious to all. One of the disadvantages is that it is time-consuming, so public health nurses are faced with determining priorities and substituting other methods, such as the group conference, the office visit, the parents' class, or even a telephone conversation or letter. Used wisely, these alternatives can extend the public health nurse's objective of family-centered care.

Public pressures for mass programs of one kind or another, often without any real determination of need, for traditional activities in schools—such as classroom talks, routine inspections of children, admissions to class, and for transportation of patients here and there—are all realities to public health nurses and the greatest deterrent to family-centered care. As normal people usually do, public health nurses tend to perform in the manner expected of them, so many continue to be "program-oriented" and "problem-centered."

Public health is changing its objectives from communicable disease prevention and control to a deeper

concern for the health of the family. This is a goal, not a program. It should be the goal of every community and society in general. All members of the healing arts must provide leadership. It is to be hoped that the physician will not only see the public health nurse's contribution to family health but will, as the medical authority, the health advisor, the chief of the health team, interpret to the community the more effective use of this resource.—IONE M. ROWLEY, R. N., director of the Bureau of Public Health Nursing, Wisconsin State Board of Health.

REFERENCES

1. Abramovitz, A. B., Ed: Foreword, p.v., *Emotional Factors in Public Health Nursing*, University of Wisconsin Press, Madison, 1961.
2. Montagu, Ashley: Anthropology and medical education, J.A.M.A. 183:577–583 (Feb 16) 1963.
3. Freeman, Ruth B.: *Public Health Nursing Practice*, W. B. Saunders, Philadelphia, 1957.

ANNOUNCEMENT OF CHANGE

Bicillin Prophylaxis Program

SINCE 1957 when the Bureau for Handicapped Children first set up a statewide Bicillin Prophylaxis Program for children with rheumatic fever or congenital heart disease the Bureau staff has enjoyed working with physicians throughout the state. The primary purpose of this program has always been to provide prophylactic penicillin at a reduced rate to those families who would be unable to assume the regular price. Administrative policies of necessity have been changed over the years to best meet the needs of this group of children. The program has continued to grow until at the present time there are over 1,500 children who receive their Bicillin regularly under this program. Seven hundred Wisconsin physicians are utilizing this service for their patients with rheumatic fever and congenital heart disease. Never has the program run more smoothly.

It has long been our concern, however, that because of statutes the Bureau for Handicapped Children cannot serve individuals beyond their 21st birthday. We feel that many of these young adults will continue to need prophylactic medication and will need the close supervision of their family physician. Since our agency is unable to provide service after the age of 21, it seemed appropriate for us to explore the possibility of using another state agency, one without age restrictions, to administer this same type of program. We have been working on this and wish at this time to announce that beginning January 1, 1964, the Bicillin Prophylaxis Program will be transferred to the State Board of Health and will include individuals regardless of age. All future inquiries after January 1, 1964, should be directed to the State Board of Health, Division of Heart Disease Control, 1 West Wilson Street, Room 420, Madison 53702.

The staffs of the University Hospitals Pharmacy, Madison, Milwaukee Children's Hospital Pharmacy (both of which have dispensed all Bicillin for us) and our own Bureau staff wish to take this opportunity of thanking all the physicians for their fine cooperation in helping us administer this program.—PATRICIA MCILLECE, M.D., *Medical Director*, Bureau for Handicapped Children.

THE PRESIDENT'S PAGE . . .

We Can, in 1964, Avoid the Royal Road to Ruin

■ P. B. JOHNSON, Chairman, Johnson & Johnson, in an address October 17, 1963, entitled "Teamwork for Public Service" ended it with these remarks: "We ask you to work with us for the common good. We make this appeal, *not* out of weakness, *but* out of strength. We have much to contribute but we cannot do it without your cooperation. Together, all of us can perform wonders, *but*, apart and disunited and distrustful of each other, we can gaily accompany each other down a long Royal Road to Ruin."

We are challenged to realistically maintain high quality medical care and to perfect our long-term health maintenance service program for Wisconsin citizens. A further challenge is to maintain our proper leadership in shaping patient care policies. This embodies carrying on an appropriate and rational organization of our resources, facilities, and personnel; and an equitable application of the powerful means at our disposal for the treatment of citizens.

The ever present problems are intensified, obscured or tempered by the inter-impacting forces of rapidly advancing technological forces upon whirling social economic changes. The latter are complicated by the efforts of pressure groups, political and allied institutions, politicians and bureaucrats. We are greatly concerned about pitfalls of over-legislation and under-legislation with their concomitant over- and under-regulations, all having a direct and frequently disturbing impact on our citizens. Truly, our citizens and patients "need a friend," and what better friend is there than a physician?

Medical issues are constantly involved to a pathological degree by political vote-seeking parties and many governmental units.

I firmly believe that the challenges can be met and the responsibilities fulfilled only by "teamed personnel" leading the teamwork within the framework of the Wisconsin State Medical Society. Most dilemmas are solved when there is realization that an individual can succeed only when he discovers how to contribute within this framework.

There can be no compromise on the question of individualism in our medical care. We shall persevere in our insistence of individual freedom in care of patients. Recent research work has demonstrated that the average individual decisions are superior to group decisions. Also that implementation is more directly done, and action is taken much more quickly. Moreover, the best public relations is that conducted at the local patient level. On the average, the data were incontrovertible in demonstrating that the quality of the individual decision is superior to group decisions—in solving realistic complex problems in a short period of time. The indi-

continued on page 514

vidual tends to "record ideas over the full range of the factors in the problem"—whereas groups may be more critical of ideas and suggestions and few of the good ideas are recorded.

Fortunately, we have excellently trained, informed, competent, and experienced physicians in all areas of our state. They are sensitive to all the human factors; and professionally able to meet any and all medical situations. Our success will be determined by the attention given to these problems and by the attitudes of each individual member toward organized medicine. It is essential that each member, as a means and a tool, be fully informed about the purposes, constitution, and bylaws, and the traditional, historical philosophy of our Society; also the principles, practices, and the cardinal principles of proper Association management.

In that, through a quiet revolutionary process, this country and its organizations are almost one hundred per cent run by managers or management—it will be helpful for us to be familiar with such principles. Our staff and administrator are best described as "guardians of the rank and file," and also as "getters-of-things-done." Working with the American Medical Association for ideas and guidance, they act for us and represent the interests of the physicians who selected and paid them.

All problems should be scientifically diagnosed to arrive at the most satisfactory solutions. Planned actions should be complete in all aspects with specific steps, concretely set forth, and instituted with proper timing. The essential self-questions are: what-how-who-when? It will be difficult as individualistic physicians to realize that our efforts will be much more effective through other people and our success will be measured by what we are able to get citizens and patients to accomplish. This has been said another way by some unknown who wrote: "When he has learned that he is writing a song that someone else will sing."

Many physicians are adverse to entering into "politics," but I seriously believe that we must do so until politics gets out of medicine. Without politics and bureaus, our country would be in a state of chaos. So each of us should help dedicated public servants to do what is best, and avoid all that is harmful. Those who are politically inept can contribute their valuable services to our educational activities.

One immediate task would be a study of effective, efficient actions and the elimination of useless procedures. This category covers such items as wasteful practices, needless duplications and dislocations, needless time-consuming duties; useless, harmful, and inefficient procedures; gaps between know-how and usage, wastage.

It may be necessary, because of the tremendous number of factors and the range of complications, to develop physicians who are, or will become, expert in the various phases of socio-economics. In other professions, this development has been called "expertise."

I am confident that if we fill our designated and essential places in organized medicine, that with constant monitoring, we will have a very successful 1964.

W. J. Egan M.D.

the WISCONSIN MEDICAL JOURNAL
Published Monthly

DECEMBER 1963
Vol. 62 No. 12

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

In Memoriam: J. F. K.

■ THE FEW WEEKS that have elapsed since the assassination of President John F. Kennedy have done nothing to dim the horror of that tragic Friday noon. When the chilling news flashed through the country, most Americans asked themselves the most unanswerable of all questions: why? Why—in the most civilized country in the world, with the longest history of democratic process—is the head of state removed by violence? Why—in the Ultimate Plan—is a young, deranged punk with a mail-order rifle permitted to snuff out the life of the man that the majority of people in this country had elected as their leader? Why?

All that sad weekend millions of Americans listened to radio reports and watched the same news films on television, even though it was known the terrible fact would be unchanged the fourth, fifth, or sixth time the same story unfolded. It was as though some hint could be found to the Why question in the numberless retelling of the story. But the hint never came, and the answer will always elude us.

But now that the deed is done and the body of John F. Kennedy is at rest, perhaps we can take a moral step forward as a result of the assassination. We can determine to hate hate as much as the haters hated him and the socially oriented program he stood for. We can strive to eliminate the curse of extremism from our midst which created the poisonous atmosphere that nourished that deranged mind in Dallas.

We can do honor to the memory of John F. Kennedy by extirpating in ourselves, as a starter, those unreasonable impulses of enmity that grow to frenzied passions. We can calm the extreme statement that creates the rationale for acts of violence. In memory of J.F.K., we can resubscribe to the moral system he represented.

"Teach us, O Lord, to hate evil." —D.N.G

In the National Spotlight

A RECENT issue of *Medical Economics* magazine described the Wisconsin Physicians Service no-fee-schedule insurance program and concluded that while the idea would spread further, doctors everywhere might not stand for it. "Tacit interference with their charging practices is something else again," said *Medical Economics*, and quoted a Milwaukee specialist who predicted that the day might come when doctors will long for "the good old days of fee schedules."

The principal idea of medical insurance is to prepay the cost of medical treatment when it becomes necessary. If doctors would accept from the insurance companies the fee listed in the patient's insurance policy for the work done, medical insurance would accomplish its purpose. In that case, the doctor's fee would be determined by what the insurance company thought that any particular procedure was worth.

Few doctors, however, are content to accept what the insurance company establishes for any procedure. Conversely, no insurance company has established a fee schedule that was universally applicable. As a result, most insured patients have only a part of their medical costs paid by the insurance company under the conventional contract, and sometimes wind up only slightly better than if they had had no medical insurance to begin with.

We would have to close our eyes to reality not to be aware of the fact that some doctors collect higher fees for a given procedure from an insured patient than from a patient who carries no medical insurance. One part of the higher fee comes from the insurance company, and the other part comes from the patient. In such circumstances, freedom from "tacit interference with charging practices" simply means freedom to consider the conventionally-insured patient as a patsy for a jacked-up fee.

Under no-fee-schedule contracts, such as that offered by WPS, the insurer becomes, in effect, the patient's agent in dealing with his doctor in matters respecting fees. The insurer guarantees to pay all of the patient's medical expense for covered procedures and doctors are permitted only one reasonable fee—their usual, normal fee, as approved by a committee of their peers in their own community.

As *Medical Economics* magazine pointed out, the idea will undoubtedly spread. The plan is attractive to patients who prefer to have their expense arising from illness handled on somewhat the same basis as is their expense arising from accident or theft. The growth of the plan in Wisconsin is proof that more families are willing to pay the heavier premium for the advantage of complete coverage. The plan has been proven to work, and to work well for both patient and doctor.

The plan isn't foolproof, however, with success depending for the most part upon the integrity and social consciousness of the doctors. If the patient's physician considers the insurance policy as something the patient has thoughtfully carried for the exclusive benefit of the doctor's continuing affluence, the no-fee-schedule plan is doomed. At the same time, the entire effort of private enterprise to keep the federal government out of the medical profession is doomed. For only through the extension of private medical insurance can the fearful prospect of bureaucratic interference in the area of health care through the social security mechanism be averted. If any doctor resents the tacit interference in his fee policy by a no-fee-schedule plan, he should bethink himself of the interference with the very source of his income that the social security mechanism would impose—or worse still, what the total federalization of our profession would bring.

The mechanisms for keeping American medicine free of government interference are at hand. In Wisconsin we know that the best of these mechanisms, from the point of view of the patient, as well as that of the physician, is the no-fee-schedule insurance contract. In order to make the contract work, the insurer and the insured must both rely on the honor and good conscience of the doctor. In setting our fees for the patient under the no-fee-schedule program, as under any other program, we must limit ourselves to the usual, reasonable, and customary standards prevalent in our communities. To do otherwise is to invite the disaster of private insurance failure and the catastrophe of federal interference. —D.N.G.

MINUTES OF COUNCIL MEETING

MADISON, JULY 27–28, 1963

1. Call to Order and Roll Call

The Council was called to order by Vice-chairman Bell at 2:15 p.m. on Saturday, July 27, at Society headquarters in Madison.

Voting members present were Doctors James, Nordby, Davis, Dessloch, Blanchard, Kief, Fox, Bell, Mason, Frank, Ekblad, Willson, Chojnacki, Houghton, Van Hecke, Wright, Past President Hill and President Egan. Also present were President-elect Curran, Vice-speaker Carey, AMA Delegates Simenstad, Quisling, Bernhart and Galasinski (latter two Saturday only), and Doctor Stovall. Staff and consultants present were Messrs. Crownhart, Toser, White, Gill (Sunday), Tiffany, Murphy, Hansen, Reynolds (Saturday), Ragatz (Sunday), Mrs. Anderson and Miss Pyre. Present for certain portions of the meeting were Drs. J. M. Wilkie and A. R. Curreri; Messrs. B. E. McGiveran and William Lumsden of Seefurth–McGiveran Corporation; Messrs. Charles Johnson and E. M. Steindler, AMA staff.

2. Approval of Minutes of May, 1963 Meeting

Doctors Blanchard–Chojnacki moved that the minutes be approved as distributed. Doctors Willson–Van Hecke offered an amendment that in the future minutes be submitted within two weeks of the completion of the meeting. Doctors Norby–Dessloch moved to amend the amendment to read four weeks instead of two weeks.

The latter amendment was carried with one negative vote and the chair ruled that this in effect defeated the initial amendment. The original motion was then carried as amended.

3. Occupational Health Guide for Hospital Employees

James M. Wilkie, M.D., of Madison, representing the Commission on Public Relations and Communications, discussed in detail "A General Guide for An Occupational Health Program for Hospital Employees" which had been distributed to the Council. This had been prepared in conjunction with the Wisconsin Hospital Association, the Wisconsin Nurses Association, and the State Board of Health, at the latter's suggestion, and intended solely as a guide.

There were several points of concern to Council members, especially the need for formalizing such a guide for hospitals in the state, and on motion of Doctors Dessloch–Kief, carried, it was referred to the Planning Committee for evaluation and report back to the Council.

4. Proposed Pension Plan for Society Members

At the request of the Executive Committee, Messrs. McGiveran and Lumsden presented a proposal for a Society-sponsored pension plan under the Self-Employed Individuals Tax Retirement Act of 1962 (H R.10), using a group annuity approach.

Doctor Willson moved that the subject be referred to the Economic Committee for further study. This failed of a second.

Doctors Frank–Blanchard moved that the State Medical Society make the plan available to the physician members through the Seefurth–McGiveran Corporation.

Doctor Willson objected to taking such important action without more opportunity for study and discussion, and moved that the subject be tabled. This failed of a second.

Doctor Dessloch felt the Society should not sponsor a single plan to the exclusion of others already available. Mr. McGiveran pointed out that there was no prohibition to the Society sponsoring any other type of plan at any time. This would simply be an offer to those interested and could be put into effect with a small number of participants, preferably before December 31, so as not to lose advantage.

The vote on Doctor Frank's motion was 6–6 and Doctor Bell declared the motion lost.

Motion of Doctors Willson–Dessloch to refer the subject to the Committee on Economic Medicine for report to the Council at the next meeting, carried.

5. American Medical Association—Education and Research Foundation

Doctor Fox took the chair at this order of business.

Mr. E. M. Steindler, Assistant Director of AMA–ERF, discussed a proposal of contacting industry leaders in Wisconsin to solicit contributions to its loan program. He sought advice on making such contacts so as not to conflict with activities of the CES Foundation of the State Medical Society.

On motion of Doctors Willson–Chojnacki, carried, this was referred to the CES Foundation with the Council's endorsement.

6. Meeting with Wisconsin Hospital Association Board of Directors

Mr. Crownhart said that arrangements for the dinner and evening meeting with the Wisconsin Hospital Association were informal and without agenda except to agree on further meetings. It was suggested that there be annual meetings of the two boards, with the Executive Committees meeting in the interim to reduce the number to perhaps a more workable size.

7. 1964 Wisconsin Work Week of Health

Mr. Reynolds presented the preliminary program outline and received suggestions from the Council on which of several alternative topics should be included.

Doctor Willson inquired whether there was any plan to charge registration fees so the Society does not have the entire burden of expense. Mr. Crownhart reminded the Council that a major justification for adding the top floor Presidents' Room in the building expansion was so that groups might be brought to meetings here rather than dissipating efforts and expense by attending large numbers of meetings held elsewhere.

8. Conference on Health Fads and Fallacies

a. Proposed Educational Television Series

In May the Council had authorized further exploration by the staff of the proposal of WHA–TV to prepare a series of 13 programs on Health Fads and Fallacies based on subjects covered at the 1963 conference.

Mr. Hansen discussed details of the method of program development and distribution to other television stations by video tape. WHA–TV will bear initial production costs, and cost to the Society of preparing video tapes would be under $2,000. The

Finance Committee reported its recommendation that the funds be provided in the 1964 budget.

On motion of Doctor Nordby, severally seconded and carried, the recommendation was approved.

b. 1964 Conference on Health Fads and Fallacies

In commenting on reports of the 1963 Conference, the House of Delegates suggested that it be continued in 1964. The staff recommended that it be held elsewhere than in Madison, and specifically at the Community Center in Port Edwards near Wisconsin Rapids.

On motion of Doctors James–Mason, carried, the Council approved further planning of the conference at this location.

9. Institute for Hospital Administrators, Trustees, and Chiefs of Staff in 1964

The Wisconsin Hospital Association felt that the second meeting similar to that held during the 1963 Work Week of Health should be held in Milwaukee with attendance expanded to include presidents or other representatives of hospital boards of trustees. The dates of April 16–17, 1964, were suggested.

The Council approved this planning and suggested, if it was not already contemplated, that representatives of lay advisory boards of Catholic hospitals be invited, as well as clinic managers, and that a longer period be provided for workshop sessions.

10. Recommendations of Commission on Scientific Medicine

a. Advertising and Exhibits

The Commission recommended (1) discontinuance of tobacco advertising and exhibits, and (2) acceptance of contraceptive advertising and exhibits.

Doctor Dessloch reported the Finance Committee's recommendation that revenue be accepted from advertisers of both products.

On motion of Doctors Frank–Nordby, carried, this subject was laid over until Sunday morning when a member of the Commission could be present, and also its proposal regarding educational television on which the Finance Committee felt further information was needed.

The Council recessed at 5:30 p.m. and reconvened at 9:20 a.m. on Sunday, July 28.

11. Walkaway Club of Wisconsin

The Commission on State Departments, through its Division on Safe Transportation recommended Society cosponsorship of a Walkaway Club whose purpose was to promote the use of automobile seat belts by publicizing traffic accidents in which occupants were spared serious or fatal injury as a result of having their seat belts fastened. Applicants approved for membership in the club will receive a lapel pin and certificate.

On motion of Doctors Willson–Nordby, carried, the Council approved co-sponsorship.

12. National Medical Foundation for Eye Care

The request of the Section on Ophthalmology and Otolaryngology that the Council approve its affiliation with the National Medical Foundation for Eye Care was laid over until Councilor Nadeau was present to discuss it.

13. Report of the Secretary

C. H. Crownhart: I feel that there are several matters that the Council would wish information on and the first of those relates to staff organization in view of Earl Thayer's impending departure and also in view of Roy's recent episode.

It's my conclusion that you don't replace a man with fifteen years' experience; rather, you hope that replacement will develop. And as a consequence it's not my intent to employ a replacement for Mr. Thayer. Dick Hansen's duties are being expanded and changed somewhat. Dave Reynolds is moving into various new areas of responsibility. I'm appointing Mary Lytle, who's been Assistant Editor in the *Wisconsin Medical Journal,* to be Assistant Managing Editor which means in substance that she's responsible, but you blame me! That's a good way to put it. She'll consult with me when she thinks consultation is necessary, but with some five, six, or seven years of experience, she has the capabilities to take over the responsibilities formerly handled by Earl.

A Medical Reporter is being added to the staff. This is a job that we've had on the books ever since about 1946 but everyone who has ever held the job has shown marked abilities and has promoted himself beyond the job and then we've looked for a replacement. The Medical Reporter's duties will be in the area of reporting, making the contacts with the newspapers, TV, etc., on the various events we hold here and the activities of the Medical Society.

Mr. Reynolds' title will be changed to that of Director of Regional Services, moving out of the more limited area of Hospital Administration. He will still maintain those activities but he'll coordinate the regional men and he will serve as back-up to Roy in connection with our Annual Meeting and our scientific activities. I've also volunteered his services to back up Roy on Interstate if Roy should run into any problem in that connection, so that he can turn to Dave to help him out.

It's my intention to employ a male, unselected at the present moment, to assist in committee activities, and primarily in the area of the Commission on State Departments. While we debate medical economics and insurance plans and socialized medicine, I think sometimes we're inclined to underestimate problems that emanate from the State Board of Health, State Board of Vocational and Adult Education, State Department of Public Welfare, and so on, and our Commission on State Departments has very real and high responsibilities in the affairs of the Society. So it's my intent to employ an individual who can be trained into the work of many of the divisions and subdivisions and subcommittees.

Bernie Maroney, a recent affiliate of the staff, a young lawyer, will specialize in the area of legislation, both state and federal. And I can tell you with a great deal of sincerity that the burden of legislation is a pretty heavy one these days, particularly that of the state which is spasmodic at times, and federal which is constant.

I think I've covered the staff organization in light of these two problems we've had.

As the Council probably also knows, our Director of Group Sales also has been ill. He's had some recurrent episodes that have hospitalized him a couple of times. We do not have a sales director at the present time, but he's Director of Group Sales and another man is Director of Agency Sales, and until the bubbles disappear from the water, Herman Toser is acting as Sales Director, at least until we can evaluate our problem in the sales area.

Now there's another matter which as Secretary I think I should bring to you with as forthright direction and clarity as I can, and it's a bit complex. I think each of you as Councilors should recognize that in electing me as Secretary or anybody else as Secretary, you elect the General Manager of the State Medical Society. If there is information you wish concerning its affairs, it should be secured through my office basically, through Mr. Toser in

the area of insurance, through Mr. Ragatz in the area of scientific medicine. I can say to you that I do not feel that it is good personnel relationship or fair to the staff for you men whom the Society regards, and whom the Society staff regards as top brass, for you to approach department heads or those holding lesser positions unless you do it in such a manner that the Secretary can kind of ease the way. You are removed from a lot of the staff. You're up in the mountains. They regard you with awe, as I do at times, but not quite so frequently, and they regard you with some fear.

There have been in all honesty, and I know of this, some reflections cast upon the status of our independent certified public accountants. It's neither my desire nor my need to defend them. They are appointed by the Council of the State Medical Society. I can't fire them which is appropriate, because the CPA's should always have the privilege of disagreeing with the general management without fear of jeopardy of their assignment, and they have that status as does Mr. Tiffany, your actuary, Mr. Murphy, your legal counsel, all of whom have been appointed by this Council and I would remind you of the fact in light of some of the undercurrents that have come to my attention.

I think their abilities and their stature and the work that they have done for the State Medical Society are not only above criticism but deserve your praise and recognition. The work that Mr. Murphy and his law firm have done, and I trained Mr. Murphy, let's make that very clear, in the field of legislation, is of the kind of stature that you would want.

A legislator in the western part of the state wrote a letter to one of our distinguished Councilors and said he had heard from Mr. Crownhart, whoever Mr. Crownhart is. Others have said they've never heard from Mr. Murphy. Others have said they've never had any information on a particular bill. Let's be realistic that the legislator lives on the votes of his constituents. But I am by and large proud of Wisconsin legislators. There's some fine and capable leadership. I don't know when this session will be over and tempers are worn a bit thin, but there are those who will alibi to their constituents and endeavor to throw the blame on me or Bob or Earl Thayer, or somebody else. And at times we are to blame. We miss the boat. We don't cover the campus thoroughly, but I think when you think of the volume of 250–300 bills and the frequent contact which has to be made, and the volume of inquiries from doctors and others, that you realize that the task is stupendous. So I won't defend Bob Murphy, either. He is a capable, loyal consultant of the State Medical Society, and to him I think you owe a vote of gratitude.

Carl Tiffany, being from Illinois, is able to sail in the pure airs of Wisconsin with less difficulty perhaps than those residents in the state. (He's a flyer which puts him in the class of Otis Simenstad.) He is an actuary. He's brought us out of the red which we knew we were going into with WPS. He participates in many meetings and has the complete respect of the staff of the State Medical Society, as I'm sure he has the respect of the Commission, as I'm sure he has of the Council.

There's the report of the Secretary. You can't work closely with these men as I have done without developing by and large an affection for them and a respect for them. Bob is affectionately known as the "Bishop." Tiffany's initials are CAT, meaning we endeavor to copy, and Don Gill is known as "Tick Tock" because we accuse him of charging by the second, and using a metronome to measure it. That, Mr. Chairman, is the report of the Secretary.

14. Report of Council Appointed Consultants

a. Legal

R. B. Murphy: Mr. Chairman, gentlemen. In an effort to economize on your time, I shall read my report.

Local Assignments of the general counsel of the State Medical Society can be grouped under four headings. They are:

1. Advice of a general nature or of general interest or application to the collective membership. In other words, the handling of questions of representative character in the area of legal medicine. It would be an impropriety to do private work or work of unique character for an individual or even for a hospital staff or a county society.

Examples of our legal studies include application of the fee splitting statute which affects the entire membership; questions involving hospital staffs, their legal structure and position; tissue committees, recurring or continuing developments in the law of malpractice, and the legal limits of delegation of procedures by a physician to a nonphysician.

2. Advice to the State Medical Society, the Realty Corporation, and the Foundation as corporations. Such advice is primarily in the area of general corporation law as applied to non-stock organizations. It also covers such areas as helping assure their continuing tax exemption, a matter of immediate concern; property rights, business insurance, defamation and legal aspects of employment.

3. Legislation. This calls, under today's conditions, for active, open and aggressive participation by organized medicine in the legislative process. It may be in the legislative forum that the ultimate independence of medicine is determined, so medicine really has no option but to participate. More importantly, it calls for patient and continuous education, first of the membership, then of legislators, public administrators, and the general populace. This necessitates the following on a day to day basis at the state level of somewhere between 175 and more than 200 bills per session of which some 25 or 30 are typically important enough to require special attention. Some are reserved by you as the Council. Others are handled by the Commission on Public Policy, others assigned to specialized commissions or staffs; and finally, after policy is made and instructions come down, your staff and registered lobbyists take over from there.

4. Prepayment plans. This is first of all Wisconsin Physicians Service, and in addition, as matters arise calling for analysis or attention, Physicians Indemnity Plan, Medicare for military dependents, VA Home Town Care, and the Wisconsin Plan.

Let me next report briefly on several matters more specifically, now that I've indicated the general areas of our activity.

One is the suit brought by the State Medical Society against Blue Cross to recover $28,000 which your Society believed was improperly withheld by Blue Cross in 1958, in what it wished to call its final accounting on agency funds. The Circuit Court for Dane County sustained the position of WPS last December and Blue Cross has recently given notice that it is appealing that decision to the Supreme Court. Since giving notice of appeal, Blue Cross has asked the Circuit Court for permission to appeal the entire trial proceedings instead of just the legal issues. Mr. Bjork, trial counsel for the State Medical Society, has opposed this effort on the basis that Blue Cross is three months late in making that request, and second, that it could well confuse the Supreme Court if the transcript went up in which Blue Cross set out five theories of the

case instead of explaining its position under the old agency contract. The Circuit Court is considering the Blue Cross request at the present time.

A second matter is the status of the podiatry suit. Early last month the Circuit Court for Dane County filed an opinion in that suit which the State Medical Society brought late last fall against the Commissioner, Mr. Manson. The decision stated that a podiatrist could not be equated with a physician and surgeon under Wisconsin law, thus overruling the contention of the Insurance Department which you found you could not live with.

Last week, the Commissioner arranged for the Attorney General to hire Mr. Elliot Walstead who was Deputy Attorney General at the time of the trial last December, and who represented the Commissioner. Mr. Manson was apparently dissatisfied with the work of two assistant attorneys general whom he thought were not representing his viewpoint adequately. This week the attorneys met, Mr. Walstead and Mr. John Kluwin, who is the Medical Society's trial counsel in this case. Mr. Manson asked that he be allowed to attend the meeting, which he did, and he brought with him a deputy, Mr. Van Cleave. It was pretty clear that the Insurance Commissioner does not agree at all with the trial court. He also expressed regret during the course of the conference that this country had not made the same kind of progress in the people's health which England has, adding that health services in the United States have already been socialized by insurance rather than by taxation, but that it is now necessary that the insurance contracts "catch up."

I think it quite possible from the tenor of his remarks that the Commissioner will be sufficiently dissatisfied with the court decision so that he will take an appeal to the Supreme Court, if he will ever approve anything the Attorney General's office does in the matter of entering judgment. That's what held the matter up for two months.

Third, there are indications that osteopaths from coast to coast, including some in Wisconsin, are assuming a militant attitude in the matter of hospital staff privileges and medical society membership. A suit demanding medical society membership was successful two years ago in New Jersey, although the outcome may have been influenced by some of the facts of the case. For one, the applicant who was an osteopath and an M.D had had two years as a provisional member of a county medical society in New Jersey. He had an M.D. degree from the University of Milan, which is an AMA approved school, but he had taken the course there in seven months because they had allowed him three years' credit on his osteopathic degree in the United States. The Middlesex County Society in New Jersey relied on an unwritten rule which had been uniformly followed that they did not recognize less than four years of ordinary residence in an approved school and on that basis turned him down.

There was some very significant wording in the court's decision which I would like you to tuck away in your minds because we may face something like this, something like this in Wisconsin. It indicates how a court thinks in a matter like this. It's one of the top state courts in the country. I quote:

"When courts originally declined to scrutinize admission practice of membership associations they were dealing with social clubs, religious organziations and fraternal associations. Here the policies against judicial intervention were strong and there were no significant countervailing policies. When courts were later called upon to deal with trade and professional associations exercising virtually monopolistic control, different factors were involved. The intimate personal relationships which pervaded the [earlier] organizations were hardly in evidence and the individual's opportunity of earning a livelihood and serving society appeared as the controlling policy consideration.

"It must be borne in mind that the County Medical Society is not a private voluntary membership association with which the public has little or no concern. It is an association with which the public is highly concerned and which engages in activities vitally affecting the health and welfare of the people . . . It is a component part of the State Medical Society . . . Through its interrelationships [it] possesses in fact a virtual monopoly over the use of local hospital facilities."

In another section of the opinion the court said, in further explaining what it meant: "The virtual monopoly which the Society possesses in fact over the use of local hospital facilities results from the well known interrelationship between the County Society, the State Medical Society, the American Medical Association, and the Joint Commission on Accreditation of Hospitals."

Now that is a deplorable over-simplification. It indicates a pat formula which was sold to that court and successfully sold. I regret the AMA did not appear in that case as a friend of the court because they might have been able to unravel this mischief which was done at the trial level and which was taken over almost without change of wording by the higher court. That's a dangerous development because it permits the imposition of membership at the wish of somebody trained in a different discipline. I think our statutes are pretty water tight but the court might not. I'm not a court. I suggest that the Commission on Hospital Relations and Medical Education, or some other appropriate body, possibly this Council itself by reserving jurisdiction, may wish to consider promptly the desirability of a specific and uniform provision in staff bylaws which it will recommend to all staffs calling for a four year training as a prerequisite of membership. We may have some California people trained in osteopathy who might try to come in here. It was not intended, but it may happen, and there can be some confusion for the next several years. I should add that to date no other court has gone so far as New Jersey. The rule has not been adopted elsewhere, but it could be. Ideas are infectious.

Fourth, I should like to report briefly that one of the most stimulating experiences and opportunities for comparison of viewpoints and problems, and it's something always highly informative, is a meeting for Medical Society executives and legal counsel of state and large county societies held biennially in Chicago. There have been four of these. I've attended them all and they have been eminently worth while. This last spring the AMA conducted a two-day National Med co-legal Symposium at Miami Beach. It was attended by more than 700 physicians, including Doctor Karl Doege, about 75 Medical Society executives, and more than 400 attorneys, largely from the southern states, although the midwest was well represented. It gives us a very real opportunity to run somewhat ahead of the trends.

Finally, it's my pleasure to report that on August 1, a very personable young man will be associated with our firm who has a special background and interest in legislation. His name is William Pharis Horton. He hails from Minneapolis. He was graduated with honors, first at Dartmouth, and more recently at Georgetown University Law School. During the past two years he has been administrative assistant for Congressman Tom Curtis of St. Louis. Mr. Curtis is one of the most distinguished and able of the Republican leaders of the Congress, and a ranking member of the Ways and

Means, a very staunch friend of medicine. Mr. Horton has had an unusual introduction to federal legislation, including draftsmanship, attendance at hearings, observation of lobbying methods, on the other side of the fence. He is anxious to make legislative work a part of his legal work. His record is one of great promise which I anticipate should be fulfilled.

This completes my report.

b. Actuarial

Mr. Tiffany: Doctor Fox, members of the Council. It's a pleasure to be here again and report to you something about the actuarial health of the insurance activities of the State Medical Society. The actuary's responsibilities cover a more narrow area than the other consultants pertaining as they do to the activities of WPS, in a staff function largely, advising and working with members of the staff developing coverage definitions, language reviewing, modifying underwriting regulations, and establishing or computing premium structure. I can report to you without reservation that in my judgment the actuarial matters of WPS are healthy. I have tried to organize my report to you in three parts, old or continuing business, new business, and for want of a little better term, perhaps, the philosphy of the business as it pertains to some of our future problems.

Under the heading of "old or continuing business" I think it will be of interest to you to know that the loss experience under the several coverages, hospital, medical-surgical, have been stable during the past year. For your information, to be specific, for example, hospital business on single subscribers has varied from 88 to 91% during the past year; on families from 86 to 87%. On our medical-surgical coverage from 84.3 to 87.8%, and on our Major Medical coverages, single subscribers from 36.2 to 35.6%, and family 34.6 to 38.2%. By way of explanation, Major Medical experience develops very slowly. This does not reflect the complete maturity of claims already incurred. For example, a careful study of the Major Medical claims under the State Employees Group indicates that the average claim will cost very nearly $1,000, but it will be dispersed over quite a number of years. The experience under hospital and medical-surgical coverages matures much more rapidly, it occurs with higher frequency, and the claims are of shorter duration and amount. WPS has a very good statistical system. I see the loss experience, not only these aggregate figures, but subdivided by the various classes and sizes of coverage within these categories, monthly.

In the area of "new projects" during the past year we have considered a waiver of premium benefit, to pay the premium on these coverages while the subscriber and/or dependents were disabled. We have developed and offered a prescription drug policy. We have spent considerable soul searching work in connection with a convalescent coverage rider, and most recently, have worked alone and with a committee of the Dental Society in bringing together contract and rates and the cooperation of the dentists in offering dental coverage.

Under the heading of "future problems," I think this will be unique, perhaps the first time the subject has been broached to you in this light, but it's not too soon in my judgment to consider it. I believe we should begin to think about the amount of surplus or free reserves which should be accumulated. I think there is a maximum beyond which we could incur the unfriendly attention of supervisory authorities to the point where we could be questioned on why we are accumulating additional funds, free surplus. This is brought to mind by other situations to which I'm exposed, but I am more concerned with WPS because of our Special Service contract. I point out to you the considerable difficulties with supervisory authorities experienced by quite a number of Blue Cross organizations at the time rates need to be adjusted, where the supervisory authority wants to look into the cost of services and why the rates need to be increased, and in one very recent case in Michigan, for example, has required that Blue Cross do certain specific things regarding hospital costs and methods in order to control, is the word they used, the cost of these services to the public. If we continue, if we were to continue the accumulation of surplus funds unnecessarily in the eyes of such people, it might direct the same chain of attention to the cost of medical-surgical service.

I am not prepared to tell you what this specific figure should be as a maximum. You can find different statements as to this amount, dependent upon the authority you ask. Our own so-called Blue Shield underwriting assistance committee has a bench mark. Supervisory authorities have another. The insurance business has long had bench marks for fire and casualty business in relation to total premium volume. I'm only putting the subject on the table because I believe it should receive some consideration and be a part of our thinking.

Associated with this is the problem of broadening the usefulness of the insurance device that we have in WPS. It has been my recommendation in the past, and I would simply like to continue it, that we consider additional lines of health coverage through one device or another, specifically sick pay coverage, if you please, a term just recently coined by Allstate Insurance Company, or disability insurance. Our convalescent contract that we have explored a number of times is a step in this direction. This is correlary to the question I just raised since if we are further distributing our insurance efforts to other coverage areas, we have full justification for retaining and increasing the amount of surplus funds to protect these activities.

In general, I think I have a disposition to see an organization of this type grow in usefulness. I think this is essential not only to keep it interesting to doctors and to the public, but also to keep it interesting to those staff that are engaged in this activity and make it possible to attract better and more staff. We need to have a definite future and an expansive outlook. That's the end of my report unless there's some question.

c. Accounting

Mr. White: Doctor Fox, members of the Council, the assignment that Donald E. Gill and Company received as part of their engagement by you may be grouped in three general parts: The first is the auditing and expression of our opinion on financial statements. Second, consulting with staff on underlying accounting systems and procedures of the Society, and a third area, consulting on general matters involving financial considerations.

As for our auditing work, we have audited each division and related organization of the Society. Our audit reports, in all of which we have expressed our unqualified opinion on the financial statements for the year 1962 or fiscal years ending in 1962, have been placed in the hands of your Finance Committee for their review. In auditing, we determine for ourselves what tests and procedures we feel are necessary in relation to circumstances of the period we are auditing. There have been no restrictions placed on us in connection with our audit work.

An audit is essentially oriented toward the expression of an opinion, just as a diagnosis includes tests the physicians think are required for the formation of his opinion. We make independent confirmation of cash and receivables, and prepare

analyses of all accounts in the balance sheet. We confirm most payables. These things are generally accepted procedures in auditing. We do such other things as appear to us to be necessary—all leading to the expression of our opinion.

The accounting system and accounting procedures of the Society and its divisions and related organizations must be kept up to date and in step with changing patterns of operation. We take some initiative here and often suggest changes for consideration which appear to us to be desirable. Increasingly, as accounting proficiency has developed within your organization, many changes are originated within the staff and are presented to us for consideration and recommendations. With both of these methods we participate in relating sound accounting principles to changing operating problems. Some examples are:

Development of facsimile signature routines for administrative disbursements, and related controls.

Changes in handling branch office bank accounts consistent with personnel and organization changes.

Reviewing reports of Internal Auditor as they relate to systems and procedures and their evaluation.

We are consulted in connection with certain special matters in which our field of interest is related. During the past year we assisted in working toward implementation of an "OFFICE OPERATIONS QUESTIONNAIRE" which is intended to obtain and provide information of value to Society members regarding operating problems of their offices. Your Committee on Economic Medicine considered this project, which we recommended to you a year ago, and you approved its implementation.

Currently we are representing the Society in an examination of its affairs and accounts being conducted by the Internal Revenue Service. Present indications are that this examination—testing exempt status of the Society, its divisions and related organizations—will be intensive and complete.

Dollars are a common, though often inadequate, measure of changes. You might be interested in observing that the year 1962 reflected a volume of cash receipts totaling almost $12 million; this compares with just under $6 million in the year 1957. Total payroll of the Society for all of these operations was $883,000.00 in 1962, and compares with $383,000.00 in 1957. These figures have been rounded for easier reference and indicate only what you know to be true—that your organization is a growing one.

There was a brief period of discussion following each presentation, and at the conclusion Doctor Egan suggested that the Secretary's report be accepted and endorsed.

On motion of Doctors Nordby–Chojnacki, carried, the Council approved the Secretary's report.

15. Statement on King–Anderson

In preparation for Congressional hearings on King–Anderson legislation, the AMA had suggested submission by each state of a statement as to the local situation concerning health care of senior citizens. Mr. Murphy read a draft statement incorporating AMA suggestions on an earlier draft.

On motion of Doctors Nordby–Chojnacki, carried, the statement was approved.

On motion of Doctors Van Hecke–Dessloch, carried, the Council directed that the statement be submitted as requested over the signature of the President of the State Medical Society.

On this general subject, Doctor Van Hecke presented a letter from the chairman of the State Jaycee Committee on Governmental Affairs requesting opportunity to meet with the State Medical Society on medicare and other matters of federal legislation.

This was referred to the Committee on Health Economics of American Life for report back to the Council on any new matters of policy.

16. Commission on Scientific Medicine

A. R. Curreri, M.D., and Mr. Ragatz were present for discussion of the Commission's recommendations laid over by the Council on Saturday.

a. Pilot Television Program

The Commission proposed the development of eight half-hour teaching programs, four each by committees at Marquette and the University of Wisconsin, for telecasting over the two educational stations in Madison and Milwaukee. The programs would be kinescoped so they could be used over commercial stations at "off hours," such as early morning, by local county societies. Production costs for the series would be from $2,500 to $3,000. If funds were authorized, the Commission would proceed with the experimental program and present the telecasts during the 1963–64 academic year.

Doctor Dessloch reported that the Finance Committee recommended approval if finances were available through the CES Foundation.

On motion of Doctors Chojnacki–Nordby, carried, the Council authorized the Commission on Scientific Medicine to proceed with the development of the television programs in connection with the 1964 budget. This was understood to mean that if the project could not be financed through the Foundation, funds would be provided in the 1964 budget of the Society.

b. Advertising and Exhibits

There was considerable discussion of the considerations leading to the Commission's recommendations reported earlier.

On motion of Doctors Frank–Van Hecke, carried, the Council stated that since there is sufficient evidence to indicate that cigarette smoking is associated with poor health and is detrimental to health, until the situation is completely resolved scientifically, the State Medical Society should not accept cigarette advertising or hold exhibits at the time of the State meeting; and that contraceptive advertising and exhibits may be accepted.

17. Report of Executive Committee

The Committee met in La Crosse on July 20 and reported the following for Council consideration:

a. Health Careers Council

The Wisconsin Hospital Association, together with the Wisconsin League for Nursing, the Wisconsin Nurses Association, and the Wisconsin State Department of Nurses, has proposed the organization of a Health Careers Council to serve the entire state in the area of recruitment for all health careers. A separate agency would be established including a board of directors, full-time executive director and secretary, and a headquarters office.

Endorsement by the State Medical Society is being sought, and possible financial support to help launch the program, after which it is hoped that financing will come from public and private health agencies, foundations and industry.

The Wisconsin Health Council, of which the State Medical Society is a charter member, is interested in the possibility of sponsoring this program and the Executive Committee recommends this as preferable to establishing a new agency. It recommends

further that the Society's interest in the project be assigned to the Commission on Public Relations and Communications.

Recommendation approved on motion of Doctor James, seconded and carried.

b. Section Organization

There has been a wave of interest among the scientific sections of the Society as to their proper organization, membership qualifications, etc.

The Executive Committee recommends appointment by the Chairman of the Council of an ad hoc committee to study the matter and make recommendations.

Recommendation approved on motion of Doctors Kief–Chojnacki, carried.

c. Central Licensing

The State Medical Society, through the chairman of the Commission on Public Policy, joined with a number of professional groups in a statement of opposition to the proposed "Licensing Administration Department" contained in the tax-budget bill.

The matter is still unresolved, but assuming it is defeated this session, the Executive Committee proposes that through the Commission on Public Policy the Society call a conference of professional groups to determine long-range policy.

Approved on motion of Doctors Nordby–Kief, carried.

d. Fehrman v. Smirl

A recent Supreme Court decision for the first time limitedly invokes in Wisconsin the legal doctrine of res ipsa loquitur—"the thing speaks for itself"—in cases involving alleged professional liability. Because this doctrine is new to Wisconsin physicians, the Executive Committee approved the preparation of an article for publication in an early issue of the *Wisconsin Medical Jounal.*

Approved by Council on motion of Doctors Ekblad–Chojnacki, carried.

e. Wisconsin Council of Hospitals and Homes for the Aged

This Council wishes to adopt accreditation standards for nursing homes in Wisconsin. At a recent meeting when proposed standards were presented for approval by interested organizations invited to the meeting, A. M. Hutter, M.D., chairman of the Division on Aging of the Commission on State Departments, represented the State Medical Society. He urged that the Wisconsin Council members secure accreditation through the National Council for Accreditation of Nursing Homes recently organized by the American Medical Association and the American Nursing Home Association.

The Executive Committee expressed agreement with Doctor Hutter's position.

Affirmed by Council on motion of Doctors Dessloch–Kief, carried.

f. State Board of Vocational and Adult Education

This state board has requested a meeting with an appropriate group in the State Medical Society to renegotiate fees for services rendered to impaired persons requesting benefits under the disability provisions of the Social Security Act.

The Executive Committee recommends that this be referred to the Commission on Medical Care Plans.

Approved on motion of Doctors Willson–Dessloch, carried.

g. Cardiac Massage

Inquiries have been received concerning possible legal implications of nurses and others not physicians performing external cardiac massage.

The Executive Committee considers this strictly an emergency procedure and has authorized the preparation of a brief statement on the legal aspects.

Approved on motion of Doctors Kief–James, carried.

h. Information to Members

In 1959, Section 269.57 (4) was created by the Wisconsin Legislature to permit the inspection and copying of medical and hospital records upon written authorization and consent of the patient, without requiring the institution of a lawsuit. Such patient consent was personal to him and did not survive his death.

Because of the importance of this provision, joint interpretations were worked out by the Wisconsin Hospital Association and the State Medical Society and published in the *Wisconsin Medical Journal.*

A recently enacted amendment to the above section now provides that after the death of a patient, a consent may be signed by a personal representative or by the beneficiary of a life insurance policy, again permitting inspection and copying without court proceedings. It does not cover any other kind of policy or factual situation. It was introduced at the request of Northwestern Mutual Life and other life companies.

Staff will prepare a brief insert to bring up to date the article on page 4 of the January 1963 issue of the *Wisconsin Medical Journal.*

The Wisconsin Hospital Association asks that the Society collaborate in a joint bulletin concerning a new rule recently enunciated by the Supreme Court.

Briefly, this applies a rule relating to "entries in the usual course of business" to professional and hospital records to permit their admission in evidence without proof of authenticity. No entry or portion thereof which constitutes a medical opinion or diagnosis, however, may be admitted except by stipulation of the attorneys, or when offered against the interest of a party by whom or under whose supervision such entry or portion was made.

This is a technical legal matter, but one of which physicians and hospitals should be made aware, as it points again to the desirability of such records being most carefully maintained, without the inclusion of material irrelevant to patient care. In the Supreme Court opinion out of which this rule came, the Court refused to admit medical records of a deceased physician in part because his notes were illegible and the Court and attorneys could not agree upon what they said.

The Executive Committee recommends that the Society collaborate in preparation of the bulletin recommended by the Wisconsin Hospital Association.

Approved on motion of Doctors Ekblad–Kief, carried.

i. Information to County Medical Societies

As most physicians appreciate, a new federal law requires that those who pay interest and dividends obtain tax account numbers of shareholders, depositors, etc., and provide informational reports to the Internal Revenue Service.

Many county medical societies do have funds on deposit and are in receipt of dividends or interest from those or other holdings.

However, this brings up the matter of the tax-exempt status of county medical societies more forcibly than heretofore. In light of the entire problem, the Executive Committee recommends that the consultants prepare a bulletin to county medical societies addressed to the attention of the treasurer, pointing out this requirement and suggesting that while obtaining the appropriate account number, the

county medical society file application to enjoy tax exempt status.

The Executive Committee believes that consultants of the State Medical Society should advise with such consultants as county medical societies may obtain in their own interest, or in the case of the small medical societies with but nominal financial activity, that these services may be provided direct.

Approved on motion of Doctors Nordby–Chojnacki, carried.

j. Fall Meeting of House of Delegates

The Executive Committee reviewed action of the House of Delegates in approving the report of the Council in May 1963 and reported its interpretation that such action was to approve the calling of a regular session of the House, and this will be an annual event in the future until such time as it may be rescinded. Arrangements for the fall meeting of the House were announced as follows:

Friday, October 18:

2:00 p.m. Registration of Delegates
3:00 p.m. Call to Order
5:00 p.m. Recess
6:00 p.m. Buffet Dinner
7:00 p.m. Reference Committees

Saturday, October 19:

9:00 a.m. Call to Order and Program in Medical–Socio-Economics
10:30 a.m. Reference Committee Reports
12 Noon Buffet Lunch and Adjournment at Conclusion of Reports

Since this is a regular meeting of the House, the reference committee authorized in the bylaws will be appointed by the Speaker; delegate caucuses will be conducted by the Councilors; and committees prepared to report by this coming October will be expected to do so. It may be anticipated that the first meeting of this character may develop a hitch or two, but after the experience of one meeting those problems should be obviated.

Doctor Fox also noted that the 30-day rule will apply to the introduction of resolutions.

On motion of Doctors Willson-Kief, carried, the Council will meet Thursday night, October 17, and on Friday morning if necessary, instead of meeting in November as usual.

k. Survey Study Committee

Doctor Egan had informed the Executive Committee that the Survey Study Committee would request a meeting with it and the staff. No arrangements had as yet been made.

Other miscellaneous routines were carried out, with the referral of various matters to other committees more appropriately involved, and a number of items were held over for a subsequent meeting.

The past presidents have accepted the responsibility of studying the matter of aid to physicians with financial, health, or other problems.

18. Report of Finance Committee

Doctor Dessloch reported that the Finance Committee met Saturday, July 27, preceding the Council meeting, and other than matters already reported, took the following actions:

A. It received audits of all activities of the State Medical Society and decided to reproduce copies for the Survey Committee and later for presentation in full to the fall meeting of the House of Delegates.

B. It recommended to the Council that the group insurance program for employees be amended to include dependent hospital-surgical-medical coverage to age 23. This will be at a gross cost of $189, of which approximately $145 would be chargeable to the Society and its agencies.

C. The Western Publishing Company of Racine has donated $3,000 to the CES Foundation to implement its study of the Menominee County health problems, on the provision that the Foundation match the grant. This will require an additional $1,000 since the Medical Society has already appropriated $2,000. The Finance Committee recommended such appropriation at this time.

On motion of Doctors Dessloch–Ekblad, carried, these recommendations were approved.

D. Executive Salaries. In executive session the Council acted upon the committee's recommendations of salary adjustments or recognition checks for certain employees, and in addition approved a $5,000 bonus for Secretary Crownhart "in recognition of no bonus in several years."

19. Oath of Office

The oath of office was administered by Chairman Fox to Marvin Wright, M.D., new councilor for the thirteenth district.

20. Miscellaneous

a. Marquette University School of Medicine

In light of the informal meetings which are to be reinstituted with the Board of Regents of the University of Wisconsin, Doctors Kief and Curran had previously been assigned to contact Dean Hirschboeck regarding the desirability of similar meetings with Marquette. Doctor Kief reported that since the Medical School is separately incorporated, it was felt preferable to meet with the administrative group of department heads rather than the Board of Trustees of the University itself, and the Council agreed that such meeting should be arranged at some future time.

b. Eligibility of Certain Non-Physicians to Society Membership

Doctor Kief also reported a request of Dean Hirschboeck that consideration be given to permitting some classification of membership for professors in the basic sciences.

On motion of Doctors Kief–Chojnacki, carried, this was referred to the Planning Committee for investigation and report back to the Council on the advisability and mechanisms whereby non-medical professors in the medical schools teaching ancillary medical subjects might become eligible for membership in the State Medical Society.

c. American College of Sports Medicine

The UW Physical Education Department had recently requested Society co-sponsorship of a program by the American College of Sports Medicine to be held at the Wisconsin Center on December 13–14, 1963.

On motion of Doctors Van Hecke–Dessloch, carried, this was approved.

d. County Institutions

Doctor Kief reported that county institutions operating with financial assistance from the State Department of Public Welfare are required to have a medical director. His county society objected to this as not in the best interests of medicine and not providing complete free choice to patients, and had organized itself as a staff and elected a chief, and

the county institution will function in that manner. He proposed a state-wide study of the matter by a Society committee.

On motion of Doctors Nordby–Ekblad, carried, this was referred to the Commission on Hospital Relations and Medical Education.

21. Resignation of L. O. Simenstad, M.D., as AMA Delegate

On motion of Doctors Nordby–Van Hecke, carried, Doctor Simenstad's resignation was accepted with regret and with sincere thanks for his service.

John M. Bell, M.D., his alternate, succeeded to delegate, and on motion of Doctors Frank–Dessloch, carried, James C. Fox, M.D., was unanimously elected alternate delegate.

22. Earl R. Thayer

Suggestion was made that the Council in some manner recognize the service to the Society of Earl R. Thayer whose resignation will take effect on October 1. The Council agreed with the Secretary's proposal that he be presented with his office furnishings in behalf of the Council and staff.

23. Adjournment

The Council adjourned at 12:45 p.m.

Approved

C. H. CROWNHART
Secretary

JAMES C. FOX, M.D.
Chairman of the Council

WILSON CUNNINGHAM DAY . . . First Memorial Lecture

THE FIRST Wilson Cunningham Memorial Lecture, honoring the late Platteville physician, was presented November 7 at Platteville State College.

Dr. W. D. Stovall, Madison, delivered the memorial lecture entitled "Artful Medical Practice: Pioneer and Modern." Doctor Stovall is president of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin which sponsored the event.

Doctor Cunningham, known as the "father of medicine in southwest Wisconsin," practiced in Platteville from 1900 until his death on January 27, 1962.

The lecture was established shortly after his death by a $2,000 grant from the State Medical Society of Wisconsin to its Foundation in tribute to Doctor Cunningham's contributions to medicine and public health.

The day's events included an afternoon scientific program for physicians in the southern part of the state. Speakers were Dr. G. A. Cooper, Clinical Associate Professor of Dermatology, University of Wisconsin Medical School, Madison; Dr. W. D. Keettel, Professor and Head of the Department of Obstetrics and Gynecology, State University College of Medicine, Iowa City, Ia.; Dr. Arnold S. Anderson, Minneapolis, Minn.; and Dr. Arthur C. Kerkhof, Clinical Professor of Medicine, University of Minnesota Medical School, Minneapolis, Minn.

Sponsors of the scientific program included the Grant County Medical Society, Southwest Chapter of the Wisconsin Academy of General Practice, Eli Lilly and Company, and the CES Foundation.

A dinner at which Doctor Stovall and other special guests were introduced preceded a public meeting which honored the late Doctor Cunningham. Dinner speaker was Mr. C. H. Crownhart, Secretary of the State Medical Society.

The public meeting in the evening was presided over by Dr. C. L. Steidinger, Platteville, president of the Grant County Medical Society. In presenting the memorial lecture Doctor Stovall paid tribute to Doctor Cunningham's long history of contributions to medicine and public health.

Doctor Cunningham established the first hospital in southwest Wisconsin shortly after opening his practice in Platteville, and operated it for 36 years. He was also instrumental in the community drive which resulted in construction of the present Platteville Municipal Hospital.

In medical circles he had served as past president of the Grant County Medical Society, served on the board of directors of the State Medical Society, and was its president in 1925. Before the advent of stainless steel, Doctor Cunningham devised an ingenious set of bone plates made from young beef cattle for use in repairing fractures.

He was a director of the Wisconsin Anti-Tuberculosis Association and the Wisconsin Units of the American Cancer Society and the American Red Cross. He had been health officer of the City of Platteville for 30 years.

Doctor Cunningham is the fourth person to be honored by the State Medical Society through memorial lectures. The others are Dr. William Beaumont, a frontier military surgeon; Dr. Erastus B. Wolcott, pioneer Milwaukee physician; and Conrad A. Elvehjem, president of the University of Wisconsin and noted biochemist. Funds to support these lectures are contributed to the CES Foundation by the State Medical Society, by relatives and friends, by colleagues, and by others interested in commemorating a physician, a person, an event, circumstance, or purpose of major significance.

Dr. W. D. Stovall, second from left, was presented a commemorative medallion following his delivery of the first Wilson Cunningham Memorial Lecture November 7 at Wisconsin State College and Institute of Technology at Platteville. Pictured with Doctor Stovall are Mrs. W. D. Hoard, daughter of the late Doctor Cunningham, of Fort Atkinson; Dr. E. M. Dessloch, councilor for the Fourth District of the State Medical Society, of Prairie du Chien; and Dr. G. A. Cooper, one of the guest speakers at the scientific program, of Madison.

REPORTS AND TRANSACTIONS OF 1963 INTERIM SESSION HOUSE OF DELEGATES

State Medical Society of Wisconsin

OCTOBER 18-19, 1963

TABLE OF CONTENTS

REPORTS

Report of Survey Study Committee 527

Manuals of the State Medical Society of Wisconsin and Related Organizations 529

Report of Council 529

Report of Commission on Medical Care Plans 530

Report of Executive Committee of the Charitable, Educational and Scientific Foundation 531

Report of Commission on State Departments .. 532

Report of Division on Aging of Commission on State Departments 533

Report of Division on Nervous and Mental Diseases of Commission on State Departments 533

Report of Division on Public Assistance of Commission on State Departments 534

Report of Division on Handicapped Children of Commission on State Departments 534

Report of Commission on Public Policy 535

Report of Commission on Public Policy and Ophthalmologic Legislative Committee 536

Report of Commission on Scientific Medicine 537

Resolution No. 1 539

Resolution No. 2 539

Resolution No. 3 539

Resolution No. 4 540

Resolution No. 5 540

Resolution No. 6 540

Resolution No. 7 540

Resolution No. 8 540

Resolution No. 9 540

Resolution No. 10 540

Resolution No. 11 540

Resolution No. 12 540

Resolution No. 13 540

Resolution No. 14 541

TRANSACTIONS

Friday Afternoon Session 541

Report of President of Woman's Auxiliary .. 542

Report of President 542

Report of Council 543

Special Report on Out-of-State Meetings 544

Report of Secretary 545

Saturday Morning Session 548

Report of Reference Committee on Reports of Officers 549

Report of Reference Committee on Reports of Standing Committees 549

Report of Reference Committee on Resolutions and Amendments to the Constitution and Bylaws 550

ATTENDANCE AT HOUSE OF DELEGATES .. 557

REPORTS PRESENTED TO THE HOUSE OF DELEGATES AT INTERIM SESSION

State Medical Society of Wiconsin October 18–19, 1963

The Interim Session of the House of Delegates of the State Medical Society of Wisconsin was held at the State Medical Society headquarters in Madison, Wisconsin, on October 18 and 19, 1963.

Presented below are reports submitted to the House. Following these reports is the transactions of the House which includes the recommendations of the reference committees and the House actions on these reports.

■ REPORT OF SURVEY STUDY COMMITTEE

This is the report of the seven man committee authorized by the last House of Delegates to review and study the Program and Management Survey of the State Medical Society of Wisconsin by the management consultant firm of Booz, Allen and Hamilton, Inc.

Your resolution provided that two members of the committee be appointed by the incoming president of the Society, Dr. W. J. Egan. These were Gamber F. Tegtmeyer, M.D., and Ralph P. Sproule, M.D., Milwaukee. Two members were appointed by the Chairman of the Council, Dr. James C. Fox. These were J. H. Houghton, M.D., Wisconsin Dells, and Paul B. Mason, M.D., Sheboygan. Three members were to be appointed jointly by the Speaker of the House, Dr. Robert E. Callan, Milwaukee, and the Vice-Speaker, Dr. H. W. Carey, of Lancaster. These were L. W. Schrank, M.D., of Waupun, C. J. Picard, M.D., Superior, and myself, J. C. Griffith, M.D., Milwaukee. The President, Speaker and Vice-Speaker served in ex officio capacity and did not vote.

At our first meeting, June 17, 1963, Doctor Tegtmeyer was selected as Secretary. Doctor Houghton as Vice-Chairman and myself as Chairman.

Your committee has worked long and diligently in these four months to study the report. It has had five meetings covering eight days and some 80 hours. It has met with the Executive Committee of the Council, with the staff of the State Medical Society, and with an ad hoc committee of the Board of Directors of Milwaukee County. It has had personal appearances and testimony from Fond du Lac and Green counties, and communications from Waukesha, Wood, Eau Claire, La Crosse and Marinette counties, and it has conferred with the firm of Booz, Allen and Hamilton. The Committee considered the report as a management study of a professional society by a firm of business management consultants. It is of the belief that the State Medical Society has been generally efficiently and honestly managed, but that this survey discloses many areas where constructive reorganization is indicated.

Many of the recommendations contained in the report are already in effect. Some have been instituted and some are in progress of development since the publication of the report.

The complete report has been studied in detail and the proposals have been approved, modified and accepted, or rejected; and in those areas of wide variance of opinion among those who appeared before or communicated with the committee, these portions of the report have been marked as requiring further study.

Included in this category are the important questions concerning the status of the secretary, the legal counsel and legal assistant, and the organization and administration of the State Medical Society, as well as recommendations pertaining to county societies. Also requiring careful study is the entire question of the Council, the reapportionment of its districts, the terms of office of councilors, the holding of multiple offices, the committee structure, the Charitable, Educational and Scientific Foundation and the Realty Corporation, as well as the relationship between the scientific, salaried and practicing physicians in the state and county medical societies.

Your committee offers 10 resolutions which you have received together with recommendations covering those items of the report it has had time to give sufficient study.

In regard to the very important matters listed above on which no decision has been reached, the opinion of the committee is that the four months it has operated is entirely too short a time to give these matters the consideration they deserve, and it is requested that the committee be continued for another year.

This is a unanimous report, signed by:

J. C. Griffith, M.D., Chairman

J. H. Houghton, M.D. — P. B. Mason, M.D.
G. F. Tegtmeyer, M.D. — L. W. Schrank, M.D.
R. P. Sproule, M.D. — C. J. Picard, M.D.

RECOMMENDATIONS OF THE SPECIAL SURVEY STUDY COMMITTEE ON THE BOOZ, ALLEN & HAMILTON REPORT

p. 225 *Parts One and Two*

Your Committee is in accord with Parts One and Two of the report as they describe the philosophy, objectives, programs and services of the State Society and recommend that future programs be directed to the changing needs of the physician and the medical profession. Your Committee agrees that programs and services of the Society should be developed continuously to meet varying needs throughout the state and that new programs should be added as needed to the Society's already expanded scope of activities. No further action is deemed necessary on this portion of the report.

p. 226 *Field Services*
7(1)

Your Committee firmly recommends that the Field Services staff should continue to operate, but that the program be kept under review.

p. 226 *Assistance to County Medical Societies*
7(2)

Your Committee recommends that the State Medical Society continue to aid the component societies and render those services that are practical and reasonable, and that the State Medical Society and its component societies should make full use of the programs and the materials supplied by the American Medical Association.

p. 227 *Relationship With Other Professional Groups*
7(3)

Your Committee recommends that the State Medical Society continue to maintain a strong relationship with other professional groups; stimulate new public educational programs; continue to study the relationship of management and labor to urban and rural health problems, and to study the medical aspects of social disorganization and health care; and appoint special committees to study these problems as the occasions arise.

p. 227 *Community Health Programs*

Your Committee commends the staff of the State Medical Society for its many excellent guides and brochures pertaining to the State Society (see appendix) and its many excellent statewide programs.

p. 227 *Relationship of Academic and Practicing Physicians*

Your Committee believes that more study and investigation is necessary concerning the relationship of the academic, salaried, and practicing physicians. It would point out that independent study and investigation is underway and a report of this special study will be made at a later date. Your Committee agrees that the State Society should continue regular program appraisals and membership surveys.

p. 228 *Tenure of Delegates*
4(3)

Your Committee recommends that the terms of delegates from the county societies be no less than two calendar years, and that where a society is entitled to more than one delegate, so nearly as possible an equal number shall expire each year. The number of terms allowed shall be left to local discretion.

This requires an amendment to Chapter III, Section 2, of the Bylaws, suggested as follows:

"Terms of delegates and alternates shall be on a calendar year basis, shall be for at least two years, and where a county society has more than one delegate shall be so determined that the terms of an equal number shall expire annually."

p. 228 *Scientific Sections*
4(5)

The portion of the report dealing with representation of Scientific Sections in the House of Delegates was not received favorably by the Committee. It therefore recommends that the Scientific Section in the House of Delegates remain as it is pending further study by the ad hoc committees.

p. 228–9 *Duties of Delegates*

Delegates should maintain strong relationships with their component societies.

At a meeting of every county society called after the district caucus and before the annual meeting of the House of Delegates, each delegate (or a representative of the delegation from larger societies) should explain to the county society membership every matter of importance which will be acted on at the annual meeting. He also should seek and appraise the opinions of the members on these issues.

Following all meetings, delegates shall prepare and deliver to an early meeting of each county society a concise report of actions taken at the meeting. They also should indicate the nature and extent of their participation in these actions and decisions.

During the year, delegates should determine the needs of the membership in each county society and should keep aware of developments in the state society and Council.

Delegates should request assistance on these matters from the staff of the State Medical Society, particularly in receiving a digest of all actions taken at meetings, approved by the presiding officer, at an early date following each meeting.

p. 229 *Reference Committees*

Your Committee has reviewed the recommendation made in the report to the effect that Reference Committee members should have no other responsibilities at annual meetings. Your Committee does not agree with this recommendation because the meeting time of the Reference Committees has been changed and coordinated so that the Reference Committee members will not have to divide their time between several committees. Your Committee recommends that the Reference Committees continue to be appointed by the speaker, at least six weeks before the date of the meetings, and that the membership of each committee continue to be reasonably representative geographically, and that at least three weeks in advance of the meeting, members of the Reference Committee receive comprehensive information relating to all matters to come before their committee insofar as this can be determined at that time.

p. 229 *Candidates For Councilor*

The Booz, Allen & Hamilton report recommends that a change should be made in the method of selecting candidates for councilor positions. Your Committee does not agree with the report and recommends that candidates for councilor continue to be selected by caucus of Delegates from each district and elected by the House.

p. 231 *Procedures to Improve Council Meetings*
5(8)

Your Committee recommends that the following procedures be adopted in order to increase the effectiveness of Council meetings:

At least three weeks before each meeting, the Chairman of the Council, with advice from the secretary, should establish an agenda. This should clearly list all matters to be considered at the meeting in the sequence in which they are to be considered. It should also estimate the amount of time needed for each item. At this time, it should be determined which staff members, advisers, or other persons should be in attendance at the meeting.

At least two weeks prior to each meeting, (except the meeting following the annual meeting of the society), each councilor should receive the agenda and information which will assist him in dealing with issues to come before the Council.

Included in the information sent to councilors should be brief staff papers on issues of special significance on which the Council is expected to act. Each such paper should contain the following elements: (1) a statement of the issue, problem, or question, (2) pertinent facts, (3) summary statements in support of and against alternative actions, and (4) staff recommendations.

All material prepared for the Council should be marked "action required," "for information only," or "long range planning," so that councilors will be able to allocate their reading time effectively.

At each meeting, staff members should be prepared to discuss matters covered in the above papers if and as requested by the Council.

Within two weeks after each Council meeting, each councilor, officers and AMA Delegates should receive draft minutes of the previous meeting.

At each Council meeting, final approval should be given to minutes of the previous meeting.

All councilors should receive brief (one page or less) minutes of each meeting of each Council committee approved by the chairman of the committee within two weeks following the meeting.

The chairman of the Council should determine which staff members and consultants should attend each Council meeting.

p. 233 *Liaison*

The Council should maintain effective liaison with appointed committees. It is recommended that brief reports of all committee meetings should be available for each councilor at meetings of the Council.

p. 234 *Selection of Officers*

6

The method of selection of officers should be improved and their roles clarified.

6(3)

The roles of society officers should be clarified.

6(3.1)

The president of the state society should provide vigorous leadership in developing and supporting policies and objectives.

The president should carry out the ambassadorial function between Wisconsin physicians and those in other states.

The president should not bear executive responsibilities.

The president should make appraisals of matters which the Council, occupied to a considerable degree with the month-to-month activities of the Society does not have the opportunity to study. He can see and advise on trends, long term changes, and possible new developments.

The president, when he feels it useful, should appoint ad hoc committees to study various aspects of the Society such as organization, program, services, or administration.

The president should bring to the Council a current perspective on how the Society is viewed by different groups, and in what areas improvements seem most needed.

The president also should present to the membership the problems facing the profession and the policies and program alternatives and actions he advocates.

6(3.2)

The president-elect should assist the president and, in the process, crystallize his understanding of the needs of the medical profession.

6(3.3)

The speaker and vice speaker should be responsible for the effective functioning of the House of Delegates.

■ MANUALS OF THE STATE MEDICAL SOCIETY OF WISCONSIN AND RELATED ORGANIZATIONS

ACCOUNTING

1. Negative Billing Manual
2. Accounting Procedure Manual

CLAIMS

1. Claims Procedure Manual
2. Claims Manual Guide
3. Guide to County Advisory Committees
4. Hospital Contract Manual
5. State of Wisconsin Manual
6. Century Plan Contract Manual
7. Drug Contract Manual
8. Federal Employee Manual

GENERAL ADMINISTRATION

1. Executive Policy Manual
2. WPS Administrative Manual
3. Index to House of Delegates Actions
4. Index to Council Actions
5. Procedural Manual on Functions of the Assistant Secretary in Charge of Scientific Education Functions of the State Medical Society
6. Membership Manual
7. County Secretaries Manual

INTERNAL AUDITOR

1. Internal Audit Manual
2. Record Retention Manual

OFFICE SERVICES

1. Purchase Routines and Procedure Manual
2. Secretarial Services Manual
3. Mailroom Procedure Manual
4. Building and Rules Manual
5. Instruction Manuals on Building Equipment

PERSONNEL

1. Position Description Manual
2. Personnel Administration Manual
3. Employee Handbook (given to all employees)

PUBLIC INFORMATION

1. Public Information Manual (March of Medicine included)
2. Selective Service Manual
3. Wisconsin Medical Journal Policy Manual
4. Physicians Placement Manual
5. Special Mailing List Manual
6. Regional Representatives Manual

SALES

1. WPS Group Leaders Manual
2. SMS–WPS Physicians Manual

UNDERWRITING

1. Medicare Procedure Manual
2. Agency Underwriting, Administration and Rate Manual
3. Rate Control Procedure Manual
4. Procedure Manual, Non-Group Health Underwriting
5. Contract Issue Procedure Manual
6. Interplan Transfer Procedure Manual
7. Group Enrollment Procedure Manual
8. Group Underwriting Procedure Manual
9. State of Wisconsin Unit Procedure Manual
10. IBM Procedure Manual
11. Group Underwriting Manual
12. Coverage Manual
13. Manual of Statistical Codes

■ REPORT OF COUNCIL

James C. Fox, M.D., La Crosse, Chairman

Since adjournment of the House sine die in May, there have been 43 committee and other meetings dealing with affairs of the State Medical Society. Most of these have been held in the state offices, including a two-day meeting of the Council on July 27 and 28. There are five committees composed of councilors, and the Finance Committee met in July, the Executive Committee in July and again in early October, the Planning Committee in August and again in September, and the Committee on Economic Medicine in September. The Scientific Committee of the Council is called into session most frequently when the Commission on Scientific Medicine is meeting.

The Council will hold its next meeting the day prior to the interim session of the House and doubtless some matters will be reported to the House as a result of that meeting. One under current consideration is an occupational health guide for hospital employees which has been developed by the Commission on Public Relations and Communications through its occupational health committee.

AMA–ERF is developing a program for the solicitation of gifts from Wisconsin corporations to aid in its various projects. Mr. E. M. Steindler, assistant director of AMA–ERF, appeared before the Council and sought its advice in this program so as not to conflict with the activities of the CES Foundation. It was agreed by the Council and subsequently by the Executive Committee of the Foundation that it would engage in a cooperative program of assisting the AMA. This will be reviewed

with interest as it may well indicate a mechanism that can be used in other areas as well.

The 1963 Conference on Health Fads and Fallacies has produced an interesting by-product. WHA–TV, the educational station of the University of Wisconsin, is developing a series of 13 programs which are being produced weekly at the present time. WHA–TV is carrying production costs and the State Medical Society is providing a video tape recording to make these programs available to other TV stations throughout the state. Cost to the Society will be in the neighborhood of $2,000.

Another Institute for Hospital Administrators, Trustees and Chiefs of Staff will be held in Milwaukee on April 16–17, 1964. The Wisconsin Hospital Association felt that the success of such institutes was well demonstrated during the 1963 Work Week of Health and that their values would be enhanced through bringing into the meeting representatives of governing boards as well. The Council strongly endorses the project and has urged those in charge of its planning to include representatives of lay advisory boards of Catholic hospitals as well as interested clinic managers.

In the area of scientific medicine the Council approved a proposal of the Commission on Scientific Medicine that there be developed eight half-hour teaching programs, four each by committees at Marquette and at the University of Wisconsin, for telecasting over the educational stations in Madison and Milwaukee. The programs will be video taped so that they might be used in other areas of the state, if physicians so desire, for off-hour broadcast over the regular TV stations covering the area. This project has been assigned to the CES Foundation in the hope that there may be outside financial support as well as support from the dues structure.

The Council took action to appoint an ad hoc committee to study the organization, membership qualifications, and other details of scientific sections of the Society. The following physicians have been appointed to that committee, and it is hoped that final recommendations may be made at the May meeting of the House:

Dermatology: Joel E. Taxman, M.D., Milwaukee
General Practice: J. S. Devitt, M.D., Milwaukee
Internal Medicine: R. L. Gilbert, M.D., La Crosse
Neurology and Psychiatry: R. E. O'Connor, M.D., Madison
Obstetrics and Gynecology: D. O. Price, M.D., Madison
Ophthalmology and Otolaryngology: C. G. Kirchgeorg, M.D., Neenah
Orthopedics: P. J. Collopy, M.D., Milwaukee
Pathology: J. L. Teresi, M.D., Milwaukee
Pediatrics: R. L. Myers, M.D., Green Bay
Public Health: C. K. Kincaid, M.D., Madison
Radiology: Howard Mauthe, M.D., Fond du Lac
Surgery: J. T. Mendenhall, M.D., Madison
Urology: F. M. Hilpert, M.D., Racine

One item of current legislative concern has been the proposal that there be created a licensing administration department which would bring into one administrative structure the licensing activities of many state boards, including those which license physicians, dentists, pharmacists and others in the health area. The State Medical Society joined with other professional organizations in opposing the proposal presented earlier in the session because it was felt that it had not been worked out in sufficient detail to recognize such matters as handling of complaints and the investigation and study of other matters often peculiar to one but not all of the professional groups. The Society proposes, after the current session of the Legislature adjourns, to hold a conference of interested parties to study all proposals of this character to determine what if anything might be subject to approval.

In other actions the Council approved the position of the Division on Aging of the Commission on State Departments in urging that accreditation standards for hospitals and homes for the aged be developed through the national council for accreditation of nursing homes rather than at a state level. It has also instructed the Commission on Medical Care Plans to negotiate with the State Board of Vocational and Adult Education relative to an updated schedule of benefits where medical and surgical services are rendered to impaired persons requesting benefits under the disability provisions of the Social Security Act.

This briefly summarizes actions of the Council taken during the summer months. There will be not only the October meeting, but further meetings in February and May to be reported to the House in 1964.

■ REPORT OF COMMISSION ON MEDICAL CARE PLANS—1962–1963

E. M. Dessloch, M.D., Prairie du Chien, Chairman

A Look at Results Seven Months, 1963

While some of the facts and figures presented here extend beyond June 30, 1963, one general purpose of this report is to measure statistical results for the first half of the current year against those of a comparable period a year earlier. An even more useful purpose is served by the comparison of statistical results with previously determined goals and objectives.

The growth of organizations engaged in an insurance operation is most commonly expressed in terms of earned premiums . . . the number of dollars of premiums which have actually been earned over a stated period of time.

In establishing its 1963 budget, WPS estimated that $13,000,000 in premiums would be earned in 1963. It presently appears that this figure will be exceeded by approximately $100,000. Earned premiums in July, 1963 were $78,000 greater than those of December, 1962 . . . an increase of more than 7.0%.

Earned premiums for the first seven months of the current year ($7,460,645) surpassed those of a comparable period last year ($6,065,548) by $1,395,097 . . . an increase of over 23.0%.

While the acquisition of the American Motors, Kenosha, group accounted for about half of the dollar increase referred to, the remaining half represents in itself very substantial growth.

It is noteworthy that rate revisions in some categories were made effective July 1, 1963, but that little of these adjustments are reflected in the figures given. These adjustments will, however, not only contribute to continuous premium growth but enhance the opportunity to reduce the ratio of claims incurred to premiums earned.

A second common measurement of growth, somewhat "peculiar" to the Blue Plans, is referred to as "enrollment" or "contract count."

As of December 31, 1962, WPS had 186,485 contracts . . . distributed between Surgical–Medical, Hospital and Major Medical. The hope was expressed that this figure would be increased to 200,000 by the close of 1963.

As already announced, the report on contract count as of July 31, 1963 revealed a total of 202,567 . . . an increase in seven months of 16,082.

Particularly gratifying was the fact that the Surgical–Medical contract count showed the largest increase in *number*, while Major Medical showed the biggest *percentage* increase.

We should not overlook this opportunity to mention that the writing of the Prescription Drug contract helped contract count to the extent of 1,555 at the end of July. (Since increased to almost 1,700.)

At the end of July, 1963, the count of Century Plan Contracts (12,317) was greater than had been predicted six months earlier. Annual premiums resulting from the introduction of this policy only a few short years ago now approximates $1,250,000.

"Overhead" expense, measured in terms of the ratio which administration costs bear to earned premiums, is extremely important to the intelligent evaluation of operating results. At the same time, it must be recognized that certain expenditures constitute legitimate and highly desirable investments in the future.

The ratio of WPS administrative expenses to earned premiums during the first seven months of 1962 was 12.03% . . . for the full year, 11.8%. During the first seven months of the current year this ratio was reduced to 11.7%, with some further slight improvement expected during the remainder of the year if present plans materialize. While it has not been customary to establish objective "loss ratios," (the ratio of benefits incurred to premiums earned) the constant goal of WPS has been to have each major line of insurance stand on its own feet financially. The experience of WPS over a long period of years is that benefits are utilized to a greater extent during the first half of the calendar year than during the second half.

During the first seven months of 1963, the Surgical–Medical loss ratio was below that of the same period a year ago. By contrast, the Hospital loss ratio was 1.75% higher. It is interesting to note that an operational gain of $20,490 for the first seven months of 1963 was very close to the $22,261 operating gain realized during the first seven months of 1962.

While fluctuations in the market value of securities improved the reserve picture during the first six months of last year (by $11,394) the reverse situation was true in 1963 . . . when "paper losses" on government securities were $14,745. Since this situation is not uncommon, no long-range effect on the investment portfolio is forecast.

Combining the operation and investment results we find that reserves were increased by $29,663 during the first seven months of the current year while during the *twelve months* ended June 30, 1963, they increased from $2,050,407 to $2,485,562.

Reserves at the end of the current calendar year should be close to $3,000,000.

So much for statistics. Now a few words about other objectives and other accomplishments.

The development of manpower at the administrative and technical levels continues to be the Commission's major goal. If WPS achieves it and concentrates staff energies on operating effectively within the framework of broad policy set down by the Commission on Medical Care Plans, WPS can look with optimism to the future. Considerable progress has been made in the realistic recognition that there is always room for improvement, that we're never doing as well as we're capable of doing, and no matter how good we think we are, there are those who have a right to believe it isn't good enough.

As mentioned earlier, the introduction of the Prescription Drug Contract was a highlight in achievements during the first half of 1963. As some one aptly observed, it produced in addition the kind of publicity which a million dollars in advertising couldn't buy.

And, while administration of the Special Service Contract has not been completely free of headaches, the interest displayed by a number of medical societies and Blue Plans in the "no fee schedule" concept is a tribute to the foresight of the State Medical Society of Wisconsin.

The Sales force, both Group and Agency, has been singularly successful in the retention of contracts . . . an indication that with maturity and experimentation it has found at least some of the answers to the problems which plagued it for five years.

With considerably less unproductive time on the part of our sales people, the time for the introduction of new areas of coverage is here. While the marketing of a Dental Contract, for example, may not produce spectacular results over night, the public recognition of the State Medical Society in the field of voluntary health insurance cannot help but improve its public relations image.

All in all, the first six months of the year have been kind to WPS. The Commission believes that with continued leadership and direction, an even more favorable report of results may be made next May.

COMMISSION ON MEDICAL CARE PLANS

E. M. Dessloch, M.D., Prairie du Chien, Chrm.
Charles Benkendorf, M.D., Green Bay
G. W. Carlson, M.D., Appleton
W. T. Casper, M.D., Milwaukee
M. D. Davis, M.D., Milton
K. H. Doege, M.D., Marshfield
Milton Finn, M.D., Superior
D. N. Goldstein, M.D., Kenosha
A. W. Hilker, M.D., Eau Claire
J. H. Houghton, M.D., Wisconsin Dells
Donald A. Jeffries, M.D., Shawano
Robert Krohn, M.D., Black River Falls
E. P. Ludwig, M.D., Wausau
P. B. Mason, M.D., Sheboygan
Howard Mauthe, M.D., Fond du Lac
A. J. McCarey, M.D., Green Bay
R. M. Moore, M.D., Frederic
E. J. Nordby, M.D., Madison
C. G. Reznichek, M.D., Madison
L. O. Simenstad, M.D., Osceola
J. T. Sprague, M.D., Madison
F. H. Wolf, M.D., La Crosse
W. J. Egan, M.D., Milwaukee
W P. Curran, M.D., Antigo

REPORT OF EXECUTIVE COMMITTEE OF THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION—1962–1963

W. D. Stovall, M.D., Madison, Chairman

Since the Annual Report of the Charitable, Educational and Scientific Foundation which was made in May of 1963, several new projects have been undertaken, several projects completed, and a number of previously conceived projects given further impetus toward completion. Some are continuous in character.

In this latter category fall the scientific teaching programs of the Foundation, the Museum facility at Prairie du Chien, and the student loan program.

The Museum of Medical Progress and Stovall Hall of Health during the past season have featured an exhibit on "Dentistry Through the Ages of Man" which was sponsored in cooperation with the State Dental Society of Wisconsin; the Spacemobile from the National Aeronautic and Space Administration; and twenty-one other loan exhibits from various organizations as well as the permanent historical displays.

The scientific programs of the CES Foundation for the ensuing year will include pediatrics, neurology, cardiology, orthopedics and endocrinology. Also planned are three programs on "The Acute Eye" scheduled for Dodgeville, Wisconsin Rapids, and Merrill on December 3, 4, and 5 respectively.

The student loan program is in full operation for the 1963–64 academic year, and in a recent administrative decision, the Executive Committee of the Foundation clarified the rule that interest on these loans is to start at the completion of internship.

These programs, of course, exemplify the type of activity that is "constant" from year to year, and no "end" is anticipated under present circumstances for any of the three areas mentioned.

Under the heading of projects completed and terminated are the Hearing Loss Study, the Insurance Needs of the Aged Study, and the Athletic Injuries Conference.

Among the proposals that have been reviewed with an eye on future completion is the possible construction of a Healthmobile. Several physicians in the state have suggested that some type of mechanism is needed to tell the story of medicine at various fairs, particularly the State Fair. Research on the actual cost of constructing a Healthmobile, the cost of transporting and maintaining the vehicle, and a scale model are all planned for completion by January 15 of 1964.

Also, a program is in the making to expand the Foundation's role in the placement of historical medical markers. There are presently three in the state including one honoring Nicholas Senn, M.D., at Milwaukee, an Ashland marker dedicated to Edwin Ellis, M.D., and one at the museum site in Prairie du Chien. Provisions for additional markers will assure that the public is aware of medicine's role in Wisconsin history.

A project nearing completion is the Hospitalization Cost Study which was begun in 1957 when the State Medical Society created a special fund subsequently turned over to the Commission on the Cost of Medical Care of the American Medical Association. This Commission conducted part of a similar study in this state, and its report will be released this year.

Another study planned by the Foundation has taken on a new light since funds have been definitely committed. This project is being handled by the Menominee County Study Committee and was given its first support when the Council of the State Medical Society transferred $2,000 to the Foundation in December of 1962 to assist in this study. In June of 1963, the Western Publishing Company Foundation of Racine donated $3,000 and the Society matched this grant by transferring another $1,000 to the Foundation in July of 1963.

The study will embrace the determination of the specific health conditions and problems as well as the type of health service facilities which are most needed by the residents of Menominee County. The study anticipated the employment of a nurse-educator who will work under the direction of the Menominee County Study Committee of the Foundation.

Another program nearing completion is the study of Teaching Resources in Health Education which will be ready for distribution in early 1964. This study, supported by the Foundation, will provide a listing of valuable teaching aids for teachers at all grade levels.

It is rewarding for this committee to be able to report to the House of Delegates that through the generous contributions of physicians and others, many programs have been completed, many have been given a firm foundation for continued operation, and that plans for the future are in the process of being developed. Our scope of work is naturally concerned with Wisconsin medicine, but the Foundation's scope goes beyond the borders of our state in that future operations will include the soliciting of funds for the AMA–ERF program from industry and physician members of the Wisconsin community.

Executive Committee of the Charitable, Educational and Scientific Foundation

W. D. Stovall, M.D., Madison, Chrm.
Mr. C. H. Crownhart, Madison, Secretary
A. J. McCarey, M.D., Green Bay
G. J. Schulz, M.D., Union Grove
J. C. Fox, M.D., La Crosse
W. J. Egan, M.D., Milwaukee
W. P. Curran, M.D., Antigo
R. E. Callan, M.D., Milwaukee
F. L. Weston, M.D., Madison

■ REPORT OF COMMISSION ON STATE DEPARTMENTS—1962–1963

T. W. Tormey, Jr., M.D., Madison, Chairman

The Commission itself made no report to the House of Delegates at the May, 1963 session although the Divisions on Nervous and Mental Diseases, Maternal and Child Welfare, Safe Transportation, School Health, Handicapped Children, and Visual and Hearing Defects did submit separate reports. The Divisions on Aging and Public Assistance are submitting reports to the House of Delegates at this session, neither one of which reported in May.

Since the House of Delegates will now be meeting twice a year, and in view of meeting schedules necessary for the ten different Divisions and their Subcommittees, the Commission intends that roughly one-half of the Divisions report at the spring session of the House and the other one-half at the fall session. This should not only even out the meeting schedule of the Divisions throughout the year, but will allow the House to give more concentrated attention to individual Division reports. Needless to say, those Divisions which have acute problems to be reported may do so at either session, and those Divisions whose activities become increased in volume may report more frequently.

As in the past the Commission's report is concentrated primarily on the reports of each of the Divisions which handle the individual areas of interest. The Commission takes this opportunity to direct your attention to the Division reports submitted herewith. The House of Delegates and the membership generally should be reminded that there are 104 physicians representing you on the Commission on State Departments, its ten Divisions and Division Subcommittees.

In addition, there are eight physicians, one dentist and ten non-physicians representing seven state agencies or voluntary organizations, in advisory capacities to the various Divisions. Where the occasion has called for further consultation the Divisions have been extremely fortunate in receiving professional and technical advice from several others whose cooperation and assistance were greatly appreciated.

At the May, 1962, session of the House of Delegates this Commission recommended a study and analysis of the administrative codes of the many state agencies. Our report to the House at that time set out the reasons for this study and we expressed the hope that a report could be ready for presentation to the House at its 1963 session. Although the gathering of background information and material for the study has been commenced by the staff, the Commission's study has necessarily been deferred in lieu of other activity. We are hopeful that a more complete report regarding the progress of this study can be made at the next session of the House.

The Commission reports the appointment of the following new Division members:

DIVISION ON AGING: E. P. Ludwig, M.D., Wausau
DIVISION ON CHEST DISEASES: Louis G. Nezworski, M.D., Eau Claire
DIVISION ON HANDICAPPED CHILDREN: J. J. Suits, M.D., Marshfield
DIVISION ON NERVOUS AND MENTAL DISEASES: Keith M. Keane, M.D., Appleton, and William H. Heywood, M.D., Marshfield
DIVISION ON SAFE TRANSPORTATION: E. E. Eckstam, M.D., Monroe

Reappointments were made to the following Divisions:

DIVISION ON AGING: Patricia F. Lanier, M.D., Kewaunee, and George G. Stebbins, M.D., Madison
DIVISION ON CHEST DISEASES: John Rankin, M.D., Madison, and John H. Huston, M.D., Milwaukee
DIVISION ON HANDICAPPED CHILDREN: F. D. Bernard, M.D., Madison
DIVISION ON MATERNAL AND CHILD WELFARE: Richard C. Brown, M.D., Eau Claire, William R. Kreul, M.D., Racine, T. A. Leonard, M.D., Madison and B. P. Waldkirch, M.D., De Pere
DIVISION ON NERVOUS AND MENTAL DISEASES: Jean P. Davis, M.D., Milwaukee, A. A. Lorenz, M.D., Eau Claire, and T. J. Nereim, M.D., Madison
DIVISION ON REHABILITATION: C. E. Koepp, M.D., Marinette
DIVISION ON SAFE TRANSPORTATION: James L. Weygandt, M.D., Sheboygan Falls
DIVISION ON SCHOOL HEALTH: H. K. Tenney, III, M.D., Madison, and F. W. Reichardt, M.D., Stevens Point
DIVISION ON VISUAL AND HEARING DEFECTS: Donald A. Peterson, M.D., Madison, and Richard H. Brodhead, M.D., Wausau

COMMISSION ON STATE DEPARTMENTS

T. W. Tormey, Jr., M.D., Madison, Chrm.
L. M. Simonson, M.D., Sheboygan
A. M. Hutter, M.D., Fond du Lac
H. A. Anderson, M.D., Stevens Point
J. W. Nellen, M.D., Green Bay
John R. Evrard, M.D., Milwaukee
Charles A. Wunsch, M.D., Green Bay
H. W. Carey, M.D., Lancaster
Paul A. Dudenhoefer, M.D., Milwaukee
Richard B. Windsor, M.D., Sheboygan
Meyer S. Fox, M.D., Milwaukee

■ REPORT OF DIVISION ON AGING OF COMMISSION ON STATE DEPARTMENTS—1962–1963

A. M. Hutter, M.D., Fond du Lac, Chairman

The Division on Aging was very pleased with the Wisconsin Work Week of Health and especially in relation to the portion devoted to aging. It has urged continuation of similar programs in the future and expresses the desire to participate in planning any sessions dealing with this subject.

The Division endorsed and approved the program on aging presented on May 7 in conjunction with the Annual Meeting of the Society in Milwaukee. It was determined that only M.D.s should be invited to that program and that separate conferences be developed for the lay public and others interested in the health care of the aged, perhaps during the annual Work Week of Health.

The Wisconsin Commission on Aging is holding a conference in Madison at the Wisconsin Center, on October 18 and 19, the same dates the House of Delegates meets in Madison. The Chairman of the Division will be heading up a workshop on home care programs at this conference and Division members have expressed their support. A luncheon meeting of the Division has been called for Saturday, October 19, following the conference and the House of Delegates session.

The Division is currently working on the preparation of a proposed article for the *Wisconsin Medical Journal* on "Medical Aspects of Nursing Home Operation," including such matters as certification of death. It has also given consideration to the development of a guide for physicians to services and facilities available for the care of the aged in Wisconsin.

A continuing activity of the Division is the matter of an accreditation program for nursing homes. The Wisconsin Nursing Home Association is involved through its national organization in working out an accreditation program in cooperation with the American Medical Association and the American Hospital Association. The Wisconsin Council of Homes and Hospitals for the Aged is proceeding with the development of an accreditation program of its own and the chairman is participating on an advisory committee to this group.

The Division urges cooperation by county medical societies in local programs and in developing community activity in the promotion of voluntary services for the elderly. Recent publications of the American Medical Association which are available upon request include the following:

1. "A New Concept of Aging."
2. "Senior Citizen Clubs: Their Role and Responsibility."

DIVISION ON AGING

A. M. Hutter, M.D., Fond du Lac, Chrm.
R. C. Cantwell, M.D., Shawano
Craig Larson, M.D., Milwaukee
S. E. Sivertson, M.D., La Crosse
Walter C. Kleinpell, M.D., Kenosha
George M. Shinners, M.D., Green Bay
Patricia F. Lanier, M.D., Kewaunee
George G. Stebbins, M.D., Madison
Clifford Y. Wiswell, M.D., Williams Bay

■ REPORT OF DIVISION ON NERVOUS AND MENTAL DISEASES OF COMMISSION ON STATE DEPARTMENTS—1962–1963

C. A. Wunsch, M.D., Green Bay, Chairman

The area of mental health has received considerable attention in the press and in public meetings during the last few months and will continue to receive major emphasis in the near future. Part of this concentrated activity results from recent Congressional action on two bills providing federal matching funds for the construction and establishment of community mental health facilities. The State Mental Health Advisory Committee is currently conducting local hearings in 22 areas of the state, the first of which was held in the State Medical Society offices on October 1. The Division on Nervous and Mental Diseases commends the Advisory Committee's efforts in this undertaking and urges participation by the members in their respective areas.

State Mental Health Planning Committee

The Division on Mental Hygiene of the State Department of Public Welfare has received a two year grant from the Department of Health, Education and Welfare for the establishment of a Planning Committee to study and make recommendations for the provision of mental health care and facilities in Wisconsin. This Planning Committee will be made up of representatives of voluntary groups, such as the State Medical Society, the Wisconsin Psychiatric Association, the Wisconsin Hospital Association, and Nursing Association and others, in addition to representatives of local government. The Division emphasizes the importance of representation on this Committee because of its possible impact on the future of mental health facilities and procedures in Wisconsin. The State Medical Society will be represented by one physician on the

Planning Committee, with possible further representation on working subcommittees appointed by it.

Mental Health Steering Committee

In view of the above Planning Committee organized through the Division on Mental Hygiene, the Division is reviewing its recommendation to establish a Mental Health Steering Committee under the auspices of the State Medical Society. Although there may be some duplication of efforts, the Division questions whether medicine's viewpoint will be adequately represented by one member on the State's Planning Committee. Further discussion is felt necessary concerning this Steering Committee and consultation is being sought with the American Medical Association.

Proposed Speaking and Postgraduate Education Programs

In May of this year, the Division recommended instituting a pilot program to provide postgraduate education in psychiatry for general practitioners. The Division notes that local programs are being carried out in a few areas of the state. Further plans for such a program are under consideration by the Division, along the lines recommended in its May report.

Teaching programs on "The Mildly Retarded Child" are currently in the planning stage. These programs would also follow the guides outlined in our May report, except that attendance would be open to teachers, parents and other interested persons. The Division feels this would be of benefit to other than M.D.s and that to limit to only M.D.s would not produce sufficient attendance. In this regard the Division notes that a recent one day program on mental retardation sponsored by the Wisconsin Psychiatric Institute drew 390 applications, only twelve of which were physicians.

DIVISION ON NERVIOUS AND MENTAL DISEASES

Charles A. Wunsch, M.D., Green Bay, Chrm.
Otto A. Dittmer, M.D., Ripon
Raymond Headlee, M.D., Milwaukee
Francis M. Forster, M.D., Madison
Walter J. Urben, M.D., Madison
Henry Veit, M.D., Milwaukee
Edward E. Houfek, M.D., Sheboygan
J. T. Petersik, M.D., Oshkosh
G. B. Tybring, M.D., Madison
Jean P. Davis, M.D., Milwaukee
A. A. Lorenz, M.D., Eau Claire
T. J. Nereim, M.D., Madison

■ REPORT OF DIVISION ON PUBLIC ASSISTANCE OF COMMISSION ON STATE DEPARTMENTS—1962–1963

H. W. Carey, M.D., Lancaster, Chairman

The Division has reviewed problem cases referred to it from physicians who find difficulty in arriving at satisfactory relations with local welfare officials. Some of these involve physicians practicing in counties adjoining one in which the patients receive public assistance and the welfare office refuses to pay for the physician's services. Others involved referrals to Wisconsin General Hospital and questioning the physician's treatment. Although such complaints are rare, the Division recognizes the irritation they create when they do occur.

The Division has previously recommended that all such incidents be handled at the local level, and that the Division be called upon only after all attempts at that level have failed. In this regard the Division urges each county medical society to appoint a committee of physicians to act as an advisory committee to the local welfare department regarding the health care of needy individuals. Physicians having complaints such as those referred to above could take them first to this committee.

We note that reports by public welfare agencies and others consistently use the term "medical" care when in fact they refer to all types of health care. A recent report by the State Department of Public Welfare on health care payments for public assistance recipients, covering the years 1961-62, shows that physicians receive only 9 cents of the public assistance health care dollar, while nursing care takes 47½ cents, hospitals 28 cents and drugs and medical supplies 9½ cents. Use of the term "medical" care is misleading in view of the relatively small share which is spent on care by physicians.

The Division recommends that consideration be given to substituting a more accurately descriptive term in the Statutes to avoid this false impression.

DIVISION ON PUBLIC ASSISTANCE

H. W. Carey, M.D., Lancaster, Chrm.
C. M. Carney, M.D., Beloit
E. W. Schacht, M.D., Racine
C. A. Olson, M.D., Baldwin
W. W. Meyer, M.D., Medford
L. F. Morneau, M.D., Bear Creek

■ REPORT OF DIVISION ON HANDICAPPED CHILDREN OF COMMISSION ON STATE DEPARTMENTS—1962–1963

J. W. Nellen, M.D., Green Bay, Chairman

Inasmuch as this Division presented an abbreviated report to the House of Delegates in May, 1963, it welcomes the opportunity of filing a supplementary report at the October meeting of the House.

As is known to most physicians, the Division on Handicapped Children is primarily advisory to the Bureau for Handicapped Children of the Department of Public Instruction. It assists the medical advisor of the Bureau in meeting specific problems of physician-relations, and counsels with her concerning modifications of existing programs and possible expansion of services into new fields.

From time to time individual physicians have taken issue with the fundamental policies under which the Bureau operates, and which have been formulated with advice of physicians directly associated with the State Medical Society, and approved by actions of the Council and the House. While these individual problems have not been many it seems desirable to review the current activities of the Bureau and the regulations under which they pay for medical services rendered.

It is important to point out that in many of the programs of the Bureau, such as the Bicillin program, the cystic fibrosis program, the home-bound care program, any licensed physician in the state may request services to patients. The primary source of misunderstanding is in the few, highly specialized areas, where medical services are directly purchased by the Bureau and which are restricted to Board Certified members. This applied only to certain areas of service, such as orthopedic care, open heart surgery, plastic surgery, etc. Likewise, the Bureau pays only where financial need is indicated. The Bureau does not attempt to serve families which are classified as indigent, nor does it serve families which are financially able to pay for medical services rendered. Nor does the Bureau have funds for hospitalization.

The major services of the Bureau are available to all physicians, and it should be noted that only in specialized areas, such as orthopedic surgery, open heart surgery, and plastic surgery, (in which medical services are purchased) are there any restrictions as to payments made to physicians.

It has been the consistent view of the Division that the Bureau should confine its services to areas

not served by welfare, or within the financial ability of the family to pay for services rendered. It has also been the consistent policy of the Bureau, approved by the Division, that the basic policies of restricting payment to Board members in specialized fields is sound, and should be continued. The areas of service are limited, and do not concern themselves with routine care, or the treatment of procedures such as fractures. It is the feeling of the Division that these policies, previously approved by the State Medical Society be continued, and that if individual physicians feel the policies are improperly administered, or not in keeping with modern medical practice, that such individuals present their complaints to the Division for discussion and adjudication.

In reviewing the various programs of the Division this past year some interesting observations are made concerning "trends" and demands for services:

Orthopedic Clinics

With the increase in specialist service throughout the state there has been a decrease in the demand for the continuance of orthopedic clinics, but many counties still request this service and feel that it has value to their members. In 1952, 41 orthopedic clinics were held, serving 2,705 children; in 1962 the number of clinics had dropped to 26 with 1,433 children seen. At the time the number of children enrolled in orthopedic schools has remained surprisingly constant, with 710 enrolled in 1952 and 713 in 1963. This is due to an increase in enrollment of children suffering from cerebral palsy, while true orthopedic cases have declined.

Inasmuch as the continuance of the orthopedic clinics rests entirely within the province of the county society it is felt that these services should be continued so long as there is a demand for them.

The Bicillin Program

The Division notes that since the continuance of Bicillin therapy goes beyond the age limit of 21 years, as served by the Bureau, the transfer of this program to the State Board of Health as of January 1, 1964 appears logical and should be welcomed by physicians who wish their qualified patients to remain on the program beyond the age of 21 years. The Division has been assured that the same methods of administration will be continued, and on that basis the Division urges physicians to utilize the service where financial need of the family is a factor in continued use of Bicillin for the treatment of rheumatic fever.

Open Heart Surgery

Recognizing an area of assistance in the highly specialized field of open heart surgery the Bureau has paid for cardiac catheterization and open heart surgery to the extent of the limited funds available, and has served as the official referring agency for the Regional Cardiac Centers, if requested to do so by the family physician. During this past year the Bureau has made 37 referrals to Regional Centers, and has authorized payments in 20 cases in Wisconsin (12 at Milwaukee Children's Hospital; 4 at University Hospitals; and 4 at Marshfield Clinic).

Cystic Fibrosis

This program was initiated in the spring of 1962, and from a preliminary study it would appear that the Bureau can and should be of assistance to many families where financial need is demonstrated in the area of antibiotics and equipment which is needed. Some of the families studied have three or four children with cystic fibrosis, and the cost of care in such instances is obvious. To date only 42 families have been served, with a total expenditure of $1,541 for drugs, but it is anticipated that more service will be rendered as the program is better understood by physicians. The Division urges physicians treating cystic fibrosis cases to contact the Bureau if they feel that financial assistance to the family is indicated.

New Fields

The Bureau has been considering possible services in the areas of convulsive disorders and to families incurring unusual medical expenses as a result of having hydrocephalic children. These fields are being studied, and it is hoped that at some future date the Division can report on these areas of service to the House.

The Division feels that the Bureau is operating under very competent medical direction, through Dr. Patricia McIllece, and it is hoped that the various programs of the Bureau will be accorded support and understanding by the profession. The Bureau does not wish to conduct its programs without advice of the profession, and at the same time the Bureau feels a primary responsibility to the service of children and families who experience unusual medical expenses in areas where federal or state funds are available for administration by the Bureau. The Division welcomes any comments of members on the programs and procedures of the Bureau which it has supervised with thoughtful consideration this past year.

Division on Handicapped Children
J. W. Nellen, M.D., Green Bay, Chrm.
George H. Handy, M.D., Wisconsin Rapids
James E. Miller, M.D., Madison
Lloyd P. Williams, M.D., Appleton
Robin Allin, M.D., Madison
Donald A. Jeffries, M.D., Shawano
F. D. Bernard, M.D., Madison
R. C. Waisman, M.D., Milwaukee

■ REPORT OF COMMISSION ON PUBLIC POLICY—1962–1963

R. G. Zach, M.D., Monroe, Chairman

The Wisconsin Legislature is composed of 33 Senators and 100 Assemblymen who are charged with the duty to consider and act upon 1,462 bills which have been introduced into the 1963 session. In the total number of bills introduced, 137 are of particular interest to the medical profession.

Success in passage of a Wisconsin Public Health Assistance Act (Kerr–Mills) is one of the notable legislative achievements of the Society in the past quarter century.

Also of special interest was the passage of the radiation protection act, the defeat of attempts by psychologists to obtain legislative certification and passage of a Blue Cross bill with amendments sought by the Society to prohibit contracts with physicians or dentists in the writing of sickness care benefits and continued assurance of free choice.

Three groups of practitioners are seeking to wrap themselves in the mantle of professional stature without commensurate educational qualification.

Optometry

With Bill 134, A., introduced by Assemblyman R. E. Peterson, Waupaca, the optometrists seek equal status with Doctors of Medicine both as to their services and reimbursement. Ophthalmologists advising the Commission will provide the House of Delegates with a special report on this legislation.

Chiropractic

The chiropractor never gives up in his efforts to legalize his use of the title "Doctor." Bill 568, A., would require every chiropractor to use the term "Doctor of Chiropractic" or the letters "D.C." provided that the letters are accompanied by the word

chiropractor. The bill has already passed the Assembly and is now pending in the Senate Public Welfare Committee.

Podiatry

The unrestricted right to prescribe, dispense and use narcotic drugs would be given to podiatrists if Bill 420, A., is enacted. The bill is presently in the Assembly Public Welfare Committee under the Chairmanship of Assemblyman Terry. However, legislative understanding of podiatry and its relationship to medicine is frequently overestimated. The Legislature must be informed that a detailed survey by podiatrists of their own schools reveals absolutely no evidence that podiatric education supports the use of narcotics. The podiatry report is available in full to any physician for the asking.

Basic Science

Wisconsin's bulwark against the unqualified practitioner has long been its Basic Science Act. Although Wisconsin was the first state in the nation to develop a Basic Science Law, it has failed to update that law to keep pace with advancing science and medical knowledge. With minor exceptions, the law has stood unchanged since 1925. Bill 107, S., introduced at the request of the Board of Basic Sciences would add subjects that are already part of the law in most states. The subjects would include bacteriology, biochemistry and hygiene in addition to anatomy, physical diagnosis, physiology and pathology which are required at present. Chiropractic elements seek to scuttle this important advancement in public health protection. The bill is now pending in the Senate Public Welfare Committee chairmanned by Senator Dempsey.

It will require the strong support of medicine to advance this bill to enactment.

Blue Plans

Two bills (627, A., and 628, A.) would subject all Blue Plans to detailed regulations by the Insurance Commissioner, including the setting of rates. The net effect of this legislation, if passed, would be to stifle the freedom of the Blue Plans to experiment with new and broader types of insurance protection for the people of Wisconsin. It is this freedom which has enabled the Blue Plans to set the pace and to pioneer new areas of health insurance. These bills are pending in the Assembly Committee on Insurance and Banking whose chairman is Assemblyman Kenyon of Tomah. The State Medical Society opposes these bills on the basis that neither experience nor public need justify such regulation.

Mental Health

At one time earlier in the session, the Legislature was deluged with some twenty or more bills dealing with revision of the Mental Health Act. Some had obvious merit, others had equally obvious objections and many required deeper study before their merits could be evaluated. Thus, the Society has taken the position that this session of the Legislature should take no decisive steps in revision of the Act without thorough and detailed analyses by appropriate committees or advisory groups.

Health Insurance For The Elderly

In the area of voluntary major illness insurance for the aged, Bill 300, A., would permit private insurance carriers and Blue Plans to use a pooling mechanism for offering health insurance to the elderly. The Society supports this bill with an amendment to include the Blue Plans in the pooling mechanism.

Medicine and public health have a vital interest in two other bills held over to the fall session for final action.

Regulation of Hospitals

Bill 492, A., gives "standard-setting" authority to the State Board of Health, including regulation of professional personnel in all general hospitals. A State Medical Society amendment removing physicians and dentists from such regulation has been made a part of the bill which is now awaiting action on the floor of the Assembly.

Nursing

The State Board of Nursing has introduced a bill, 525 S., which will permit them to establish minimum standards and rules for nursing practice, minimum standards for nursing schools, prevent the unauthorized practice of nursing, and promote the training of trained practical nurses in addition to their duties of examination and re-registration of nurses. This bill has passed the Senate and is now pending before the Assembly Committee on Public Welfare. It is acceptable to the medical profession in amended form.

Of the 49 public health bills held over to the fall session these demand the profession's attention and effort. The legislator can vote his informed opinion only to the extent that he acquires a clear and concise understanding of the problems and goals of public health. This task falls inevitably upon the medical profession. In the remaining weeks before the Wisconsin Legislature resumes its activity, physicians have an opportunity to provide the legislator with information "in depth."

COMMISSION ON PUBLIC POLICY

R. G. Zach, M.D., Monroe, Chrm.
W. T. Russell, M.D., Sun Prairie
Norbert Enzer, M.D., Milwaukee
L. J. Kurten, M.D., Racine
H. E. Oppert, M.D., Viroqua
E. C. Quackenbush, M.D., Hartford
C. F. Broderick, M.D., Wisconsin Dells
W. J. Egan, M.D., Milwaukee, ex officio
W. P. Curran, M.D., Antigo, ex officio

■ REPORT OF COMMISSION ON PUBLIC POLICY

R. G. Zach, M.D., Monroe, Chairman

and

OPHTHALMOLOGIC LEGISLATIVE COMMITTEE

J. V. Bolger, Jr., M.D., Waukesha, Chairman

Among the order of business when the Wisconsin Legislature reconvenes on November 4 will be Bill 134, A. This legislation introduced at the request of the Wisconsin Optometric Association by Assemblyman R. E. Peterson (R) of Waupaca is an attempt by optometrists to equate their trade with the profession of medicine in respect to services performed and reimbursement of these services.

The bill originally introduced into the Assembly provided for a "certificate of optometric evaluation" and for testimony of a licensed optometrist to be considered as expert testimony. The efforts of the State Medical Society and others eliminated these two provisions but the bill as it was sent to the Senate still contains the provision which has been highly objectionable from the date of its introduction. The bill, as it passed the Assembly, reads:

> "Any agency of the state, county, municipality, or any commission, clinic, administering board, insurance corporation, or any other person who administers relief, social security, health or other insurance, or health service, *shall accept* the services of optometrists, licensed under this Chapter, *on the same basis as those of any other person authorized by law to render similar professional services, and shall pay for such services on the same basis as other professions are paid for similar service.*" (Emphasis supplied.)

The Senate referred the bill to the Senate Judiciary Committee on May 15. This Committee, which has not yet conducted a public hearing on the bill is composed of Senators Busby (R), Milwaukee; Morton (R), Kenosha; Keppler (R), Sheboygan; Potter (R), Port Edwards; McParland (D), Cudahy; and Donnelly (D), Eau Claire.

The provision of the bill that optometric services must be accepted and paid for when they are *similar* to those rendered by an M.D. is an attempt *to equate* the services of bending light by a lens and consequently neutralizing a refractive error to the physician's services which include the study, diagnosis and treatment of a patient.

Scientific fact and not legislation is the way to determine what is a professional and what is a nonprofessional service. Services are not necessarily similar because they look alike or some one with an interest in doing so says that they are alike.

Total patient care cannot be rendered by a trade anymore today than it could be in 1940 when the Wisconsin Supreme Court in the case of *State ex rel, Harris vs. Kindy Optical Company* stated in four parts of its decision that optometry is a trade and *not* a profession. The Court was not without firm foundation when they made this decision for the educational qualifications of the optometrist are not those of any professional discipline. For example, a person possessing a "doctor of optometry" degree applying for admission to our state university at the undergraduate level will not receive even one credit for one course taken in an optometric college.

This lack of educational standards takes on dangerous aspects when associated with the widely held concept that the optometrist is *medically* trained, and when it is believed by some that the optometrist is competent to determine whether or not the services of a physician are needed. The confusion that results from this concept leads to delay in medical care with detriment to the patient that can result in blindness and even death. The public's confusion has also been fostered to some degree by professional relationships maintained with optometrists by physicians. Adding to this confusion are statements by Optometric Associations claiming that optometry is the art and science of vision care and that it is the only profession licensed . . . to examine the eyes.

The *similar* services provision of this legislation is even more objectionable in its requirement that a school nurse, county nurse, welfare worker, social worker, aid to the blind worker, rehabilitation service employee, or any other state employee is open to criminal action who advises a person to see a physician and fails to advise them that he may also see an optometrist. This would add to the public's confusion over the qualifications of an eye physician as compared to an optometrist, and would result in stifling the government worker in recommending competent medical care, or the insurance company from requiring adequate medical examinations before they pay a claim.

Bill 134, A. is only the Wisconsin version of a national picture of legislation designed to expand the practice of optometry without a corresponding improvement in the educational background. There have been cases in some states where optometrists have been officially designated or appointed as examiners in public schools. In some of these states the optometrists have gone so far as to propose legislation which would authorize them to be designated as experts in the field from which all physicians would be excluded except ophthalmologists possessing certain qualifications.

Optometrists have also developed another indirect method of increasing privileges by introducing legislation that would place legal restrictions on the work of dispensing opticians, and other ancillary workers who do their job under the supervision of a physician.

A legislative approach which is even more drastic is found in states in which legislation has been introduced which would forbid physicians from engaging in certain areas of ocular medical practice or would in the case of physicians who meet certain stipulations provide for their registration under the optometry law and their regulation by the optometry board. Legislation of this type has already been introduced in past sessions in the states of Missouri and Oklahoma and is a clear example of how legislation affecting a special area of medicine, affects the practice of medicine as a whole.

The national drive for professional status by legislation can be summed up by a quote from *Medicine, Optometry and the Public Welfare* issued by the National Medical Foundation for Eye Care.

> "Optometry laws in certain states regulate and proposed legislation in other states would regulate the physician in his practice by including him with the optometrist by the use of the term 'optometrist or ophthalmologist' or by stipulating that the 'optometrist or physician or surgeon' may do this or must not do that. It is not always apparent to the medical profession that each such provision actually modifies the medical practice act in that state inasmuch as each such new act usually repeals any previous law inconsistent therewith."

Thus, Bill 134, A. *must be defeated* if the public welfare is to be safeguarded and the Senators must be given knowledge to permit them to understand the actual goals of this legislation. Dangers which include blindness, death, and lack of training must be explained to the public, as must the difference between a trade with a *limited license* and a profession trained to render *total patient care.* The overall purposes of optometric legislation must also be stifled in this legislative session and in sessions to come. The medical profession is the one group equipped to expose the critical defects and inherent dangers, and protect the public's interest by opposing this badly conceived piece of legislation.

■ REPORT OF COMMISSION ON SCIENTIFIC MEDICINE—1962–1963

A. R. Curreri, M.D., Madison, Chairman

The Commission on Scientific Medicine has primary responsibility in the formulation of the Annual Meeting program and also to seek out methods of providing the most effective postgraduate medical education for the diverse membership of the State Medical Society of Wisconsin.

In analyzing the Annual Meeting programs of recent years, the Commission has felt that better coordination of instruction might be achieved by having individual programs devoted to one, or two basic subjects. The specialty societies have cooperated with the Commission in this regard, and it is anticipated that the 1964 Annual Meeting program will have greater depth of instruction than has been experienced in the past.

Recognizing a special responsibility in providing instruction in areas of greatest value to the member who does not devote his time to a single specialty, the Commission has asked the obstetricians and the pediatricians to prepare full-day programs, which will be presented simultaneously on the opening day of the meeting (Monday, May 11). The important subjects of "Pregnancy Wastage," pediatric hematology, and pediatric surgery will offer a great variety of instruction which will appeal to

members of the Wisconsin Society of Obstetrics and Gynecology, the Wisconsin Chapter of the Academy of Pediatrics, and the many generalists in the state.

The second day of the meeting promises to be equally interesting, and somewhat novel in its approach. Cognizant of the desire of all physicians to renew their fundamental educational teachings and to apply these to new and changing concepts of medical practice, the Commission is enlisting the cooperation of the Wisconsin Society of Internal Medicine and the Wisconsin Society of Pathologists in the preparation of a full day's program on "Medical Genetics—A Clinical Field." The sessions will cover fundamental concepts of cell structure, the function of heredity, and how the important field of medical genetics offers information of practical value to every physician. It is hoped that the reception of this new and different program will encourage the Commission to incorporate similar "horizon-stretching" instruction for future state meetings.

Concurrent with the program on "Medical Genetics" there will be an afternoon program provided by the Wisconsin Psychiatric Association devoted to the evaluation and use of anti-depressant drugs, in office use and in hospitals.

The third and final day of instruction (Wednesday, May 13) will provide a full morning devoted to trauma and dermatology associated with employment, while the afternoon will offer a variety of "special interest" programs in anesthesiology, ophthalmology and otolaryngology, radiology, and surgery.

In the formulation of the Annual Meeting program the Commission has enjoyed the finest of cooperation from various specialty societies, and it is hoped that the 1964 program in its final form will have equal appeal to the specialist and the generalist.

Regional Teaching Programs

While the traditional "circuit" teaching program has been modified in light of other teaching efforts, the Commission recognizes the desirability of offering teaching programs "at the grass roots" when and where demand exists. At the suggestion of the ophthalmologists a series of one-day teaching programs in early December are being offered on *Acute Eye Problems* in Dodgeville, Wisconsin Rapids, and Merrill. The many problems to be covered in these meetings are those common to all physicians and it is hoped that the response in terms of participation will be gratifying.

A special one-day teaching program in Platteville on November 7, planned cooperatively with the Southwest Chapter of the Wisconsin Academy of General Practice and the Grant County Medical Society, will pay special tribute to the late Wilson Cunningham, a pioneer physician in the area and a past-president of the State Society. This will be combined with an evening public meeting, and promises to be an event of note both scientifically and in terms of good public relations.

New U. of W. Teaching Courses

This year for the first time the University of Wisconsin has turned over to the State Medical Society (through the CES Foundation) the responsibility of organizing and conducting its halfday instructional courses, which are primarily intended for generalists. Through the cooperation of the Wisconsin Academy of General Practice a series of five one-day programs have been arranged, and if these are well received similar programs will be planned for the academic year of 1964–65, with a possible series of similar character developed in Milwaukee through the cooperation of Marquette University School of Medicine and the Milwaukee Chapter of the Wisconsin Academy of General Practice.

The new approach of these programs, that of selecting a small segment of various medical problems or areas of instruction and discussing them "in-depth," may provide the type of teaching which is most helpful to the physician in general practice. The Commission is viewing the response with interest.

A Novel TV Experiment

The Commission on Scientific Medicine has for several years discussed ways in which new modes of communication might be effectively utilized in the area of physician postgraduate instruction. The use of TV has been one area which suggested experimentation, and beginning with 1964 through the cooperative efforts of the two educational stations in Madison and Milwaukee (WHA–TV, and WMVS –WMVT) a series of experimental telecasts will be presented at "off hours" such as 8:00–8:30 a.m. These programs will be produced by the faculties at Marquette and the U. of W. Medical School, and will be *purely scientific in character*. The programs will be kinescoped so that physicians in other areas of the state can utilize them through regional stations, if so desired. These teaching programs will be publicized through mailings to physicians only, so that casual viewing by non-medical personnel will not be encouraged. The Commission will evaluate these programs in terms of viewers' reactions, and on the basis of physician response the programs will be continued or discontinued in 1965.

"Visiting Professor" at Selected Hospitals

It is hoped that during the coming year a special one-day teaching service provided by faculty members from our two medical schools can be developed for the medical staffs of larger, selected hospitals. This would provide a full day of "rounds," consultation on cases, and informal presentations. Possibly the hospitals served could have one full day on surgery, and a second day six months later on some basic subject in medicine. This program is still in the "talking phase," but the Commission will try several pilot programs and report their success at a later date.

Speakers Service to County Societies

For the past three years a Speakers Service has been provided to strengthen the scientific programs of component county societies. The Commission is pleased to report that for the academic year of 1962–63 the Speakers Service provided 64 speakers on scientific subjects, and of the total cost of $3,288.37, contributions from the State Board of Health, the Merck Sharp & Dohme Postgraduate Program, and the voluntary health agencies covered all costs other than $531.70 (of which $500 represented a donation for the Milwaukee County Medical Conference). A total of 1,750 Wisconsin physicians attended the 64 meetings covered by the Speakers Service in 1962–63.

The Scientific Portion of the Medical Journal

The Commission on Scientific Medicine would be remiss if it failed to comment on the contribution made by the Medical Editor and the Editorial Board of the *Wisconsin Medical Journal*. While the Journal has experienced a decline in advertising (as has been the experience with all medical publications) there has been no curtailment of scientific information in the Journal. The scientific articles have been of uniformly high quality, and the Editorial Board has made a commendable effort to encourage publication of material from younger members of the Society.

Medical Writing Awards and Photography Exhibits

Previously authorized by this Commission and the Council, the Editorial Board has established procedures for annual writing awards to be given for the three best scientific papers by Wisconsin authors published in the *Wisconsin Medical Journal* during a given year.

The Commission on Scientific Medicine and the Council have also authorized the development of a medical photography display at the Annual Meeting. The Editorial Board has recommended procedures for submission and judging of both scientific photography, and a non-scientific category which is a project of the CES Foundation.

Details of these programs will be announced in the *Wisconsin Medical Journal.*

In reviewing the status of the State Medical Society of Wisconsin in reference to scientific teaching programs and the publication of scientific material in the *Wisconsin Medical Journal*, the Commission feels that Wisconsin is well above the average in terms of service to its members. Attention has been directed to all segments of the membership, and the fine cooperation of our two medical schools, the State Board of Health, and the voluntary health agencies has provided a variety of instruction which has been of value to the entire membership. The Commission is aware of many changes in the area of postgraduate medical education, and it welcomes suggestions of how the work of the State Society in this important area of service can be improved.

COMMISSION ON SCIENTIFIC MEDICINE

A. R. Curreri, M.D., Madison, Chrm.
P. T. Bland, M.D., Westby
G. E. Collentine, Jr., M.D., Milwaukee
John K. Curtis, M.D., Madison
T. V. Geppert, M.D., Madison
Victor S. Falk, Jr., M.D., Edgerton
John S. Hirschboeck, M.D., Milwaukee

■ RESOLUTION NO. 1

Introduced by: Fond du Lac County Medical Society

Subject: Relationship with State Welfare Department

WHEREAS, There has been an ever increasing tendency for the Welfare Department at all levels to become involved in the medical care of our citizenry; and

WHEREAS, Over the years these activities have increased the demands especially within the administrative duties of the medical profession and thereby adding materially to the overhead costs of providing certain phases of medical care; and

WHEREAS, There is no clear line of jurisdiction in many of these practices; and

WHEREAS, The Welfare Department has in many cases *assumed* jurisdiction not provided by law; now therefore be it

Resolved, That the House of Delegates endorse the action taken by its Council in instigating a thorough investigation of the relationship existing between the Welfare Department and the State Medical Society in all phases; and be it further

Resolved, That definite rules of practice be established in order to prevent further encroachment into the practice of medicine by the Welfare Department; and be it further

Resolved, That the State Medical Society assert itself to the extent of informing the Welfare Department as to what is acceptable and what is not, rather than to continue allowing this Department to place demands on our County Societies and individual members without recourse and without State Medical Society approval; and be it further

Resolved, That County Societies, before acceding to the demands of the Welfare Department assure themselves through the State Medical Society that they are not committing their segment of the practice of medicine to further socialization and state agency control; and be it further

Resolved, That such items as routine reports, hospital and nursing home care, rehabilitation, fee schedules, etc., be to some degree coordinated so as to prevent complete domination by social agencies without unified supervision and control through our State Medical Society.

■ RESOLUTION NO. 2

Introduced by: Fond du Lac County Medical Society

Subject: Insurance coverage for medical care of relief and welfare recipients

WHEREAS, Present financial arrangements and methods of payment for medical care of welfare recipients at all levels are generally unsatisfactory; and

WHEREAS, These present procedures have been the cause of endless time wasted by both welfare departments and the medical profession in futile discussions concerning fees and red tape; and

WHEREAS, Both the doctor and the welfare worker have more important functions than to administer funds; and

WHEREAS, There is a method, through insurance coverage of the welfare recipient, that has been found to be satisfactory in other states; and

WHEREAS, Such a system provides a simple, business-like method that should be acceptable to governing bodies since they can predetermine annually their financial requirement controlled by adjustments based on experience ratios; and

WHEREAS, Such a system is acceptable within the Kerr–Mills legislation; now therefore be it

Resolved, That the State Medical Society of Wisconsin investigate the feasibility of offering a comprehensive insurance coverage to the State of Wisconsin applicable to the medical care of welfare and relief recipients at all levels of government—county, township, city and village.

■ RESOLUTION NO. 3

Introduced by: Fond du Lac County Medical Society

Subject: Insurance forms and reports

WHEREAS, Present demands for insurance reports of all kinds from the medical profession have increated to the extent that they represent a major administrative expense and time consuming process; and

WHEREAS, Every type of insurance coverage demands different information; and

WHEREAS, Every insurance company has its own variations as to blanks to be completed; and

WHEREAS, As much time and effort must be expended to complete these individual forms; and

WHEREAS, It would be a simple matter to have available such information as one would require if one knew beforehand what report would be required; and

WHEREAS, Reports could be completed faster, easier, and at less cost if this present multiplicity was done away with; now therefore be it

Resolved, That the State Medical Society with the aid of our A.M.A. Delegates on a national level, further expedite present efforts to standardize insurance reports of all kinds.

■ RESOLUTION NO. 4

Introduced by: La Crosse County Medical Society

WHEREAS, The State Medical Society of Wisconsin is composed of physicians from all parts of Wisconsin including those from the western half of the State; and

WHEREAS, The annual meeting of the State Medical Society has not been held at La Crosse or a city outside of Milwaukee for several years; and

WHEREAS, The State Medical Society did meet in La Crosse, Wisconsin, at one time; and

WHEREAS, The city of La Crosse is easily accessible by means of automobile, airplane, and train; and

WHEREAS, The city of La Crosse has motel, hotel, and restaurant accommodations capable of handling a convention of three thousand people plus an auditorium which seats four thousand persons; and

WHEREAS, The physicians of La Crosse County are desirous of having the State Medical Society hold its annual meeting in the city of La Crosse; therefore be it

Resolved, That the La Crosse County Medical Society does invite the State Medical Society of Wisconsin to have its annual meeting in La Crosse, Wisconsin, in 1965 or 1966.

■ RESOLUTION NO. 5

WHEREAS, It is increasingly apparent that the business of the society is now of such magnitude that it could best be handled at two sessions of the society each year; be it therefore

Resolved, That the Constitution and Bylaws of the Society be amended as follows:

Amend Chapter III, Section 1, Bylaws, by adding the same sentence used by the AMA: "The House of Delegates shall hold one interim session each year."

■ RESOLUTION NO. 6

Resolved, That the House of Delegates, at its Fall meeting, receive and consider the programs of the Society and their supporting budgets for the ensuing year.

■ RESOLUTION NO. 7

Resolved, That the fiscal year of all organizations of the Society commence on January 1 and extend through December 31.

■ RESOLUTION NO. 8

Resolved, That the Council receive annual reports and recommendations for new programs from the chairman of all committees sufficiently in advance of the Fall meeting to permit the program planning and budget committees to make accurate appraisals and recommendations to the House of Delegates at the Fall meeting.

■ RESOLUTION NO. 9

Resolved, That all appointments to the committees of the Council shall be made at the organizational meeting of the Council which shall be held immediately following the annual meeting.

■ RESOLUTION NO. 10

Resolved, That reports of all committees be available to the Council at least six (6) weeks before the meeting of the House of Delegates to which they are to be submitted.

■ RESOLUTION NO. 11

WHEREAS, There should be a consistent policy regarding reimbursement of members for expenses necessarily incurred in attending meetings of the Society; now therefore be it

Resolved, That the Council shall establish a policy and include in its annual budget funds to cover travel and other reimbursable expense items of the councilors and officers and all committee members; and be it further

Resolved, That the budget for the Council meetings be a part of the general budget to be provided by the House but as a separate item so that the expense can be effectively evaluated by the House.

■ RESOLUTION NO. 12

WHEREAS, your Committee has studied the various possibilities suggested by the survey and has taken into consideration several other possibilities concerning the relationship of the two Blue Shield Plans within the state; and

WHEREAS, The suggested ideal situation would be one "Blue Plan"; and

WHEREAS, This is impractical and untimely; and

WHEREAS, Both plans are successfully operating; now therefore be it

Resolved, That Wisconsin Physicians Service of the State Medical Society of Wisconsin and Surgical Care, the Blue Shield Plan of the Medical Society of Milwaukee County, continue to operate independently under their present structure and that each operate throughout the state under fair competition.

■ RESOLUTION NO. 13

Amendment to Article VIII, Section 3 of the Constitution of The State Medical Society of Wisconsin.

WHEREAS, Section 3 of Article VIII of the Constitution reads, "Special Meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates"; and

WHEREAS, This section has created confusion among the membership of the Society and has been interpreted by the legal counsel of this Society that a special session of the House can be called only by the Council, acting on the petition of twenty or more delegates, or on its own motion, and that the date, time, locations and arrangements for a special session are determined exclusively by the Council . . ."; and

WHEREAS, Such an interpretation by the legal counsel limits the authority of the legislative and governing body of the Society, the House of Delegates, to reconvene when it desires to; and

WHEREAS, The Bylaws of the AMA, Chapter IX, Section 3, Paragraph B, empower the Speaker to call special sessions of the AMA House of Delegates, upon proper requests of the required number of delegates or request of the majority of the Board of Trustees; now therefore be it

Resolved, That Article VIII, Section 3, of the Constitution of the State Medical Society of Wisconsin be amended by striking out the present Section 3 of Article VIII and substituting the following Section.

"Section 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 25% or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the Special session is to be held. The notice shall specify the time and place of the meeting and the purpose for which the session is called, and the session shall consider no business except that for which it is called."

Since this resolution requires an amendment to the Constitution, it is introduced at this time only, to be acted upon in May, 1965.

■ RESOLUTION NO. 14

WHEREAS, It is becoming apparent that the voluminous historical material available to the members of the State Medical Society must be catalogued and recorded; now therefore be it

Resolved, That the position of Historian be created; that he shall be a physician appointed by the Council; that the term of office shall be established by the Council; and that the Historian shall receive reimbursement for expenses and shall report at least annually to the Council. It shall be the duty of the Historian to catalogue the materials available and supervise the recording of official actions and the preservation of biographic data.

TRANSACTIONS OF HOUSE OF DELEGATES

INTERIM SESSION • OCTOBER 18–19, 1963 • MADISON

FRIDAY AFTERNOON SESSION

October 18, 1963

The first session of the House of Delegates of the State Medical Society of Wisconsin, held at the Headquarters Building, Madison, on October 18 and 19, 1963, convened at 3 p.m., Dr. R. E. Callan, Speaker of the House of Delegates, presiding.

Speaker Callan: You will recall that at its 1959 session the House of Delegates directed that each future session would be opened with the reading of Article II of the Constitution and Bylaws, entitled, "Purpose".

"The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life."

As Speaker I wish to emphasize that the House is a legislative body and its processes are democratic. No delegate should hesitate to present his views. By precedent, discussion has been limited to five minutes for each speaker and may be extended by permission of the House. Each member is asked to give his full name and the county society he represents when he addresses the Chair.

Announcements of reference committee appointments is made at this time. I have appointed the following:

To the Reference Committee on Reports of Officers:

J. V. BOLGER, JR., MD, Waukesha, Chairman.
H. F. TWELMEYER, MD, Wauwatosa
F. M. HILPERT, MD, Racine
C. J. STRANG, MD, Barron
M. V. OVERMAN, MD, Neillsville

To the Reference Committee on Reports of Standing Committees:

F. E. GEHIN, MD, Stevens Point, Chairman.
G. W. HILLIARD, MD, Milwaukee
W. T. RUSSELL, MD, Sun Prairie
J. E. MARTIN, JR., MD, Delavan
D. R. GRIFFITH, MD, Eau Claire

To the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws:

T. J. NEREIM, MD, Madison, Chairman.
E. P. ROHDE, MD, Galesville
G. A. BEHNKE, MD, Kaukauna
L. E. FAZEN, JR., MD, Racine
G. E. COLLENTINE, JR., MD, Milwaukee
L. W. SCHRANK, MD, Waupun
C. J. PICARD, MD, Superior

The Committee on Credentials is composed of Drs. D. J. Carlson, Milwaukee, Chairman; W. D. Hamlin, Mineral Point, and J. W. Boren, Jr., Marinette. Will the Chairman please report?

Dr. D. J. Carlson [Milwaukee]: The Committee on Credentials has verified the registration of 68 delegates and 10 alternate delegates entitled to vote at this session of the House of Delegates.

Also, the Credentials Committee has been informed that the following will act as delegate for the regular delegate and alternate who are unable to attend:

L. F. Gulbrandsen, MD, for Vernon County
P. B. Blanchard, MD, for Ozaukee County
C. W. Dean, MD, for Milwaukee County
John Kreher, MD, for Ashland–Bayfield–Iron Counties
George Parke, MD, for Richland County

I move that the attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 78, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

(Motion seconded and carried.)

Speaker Callan: We are privileged to have with us today the president of the Woman's Auxiliary, Mrs. W. D. James, who will now address the House.

REPORT OF PRESIDENT OF WOMAN'S AUXILIARY

Mrs. W. D. James: I promised to speak for only five minutes, so I will skip all the preliminaries and come directly to the answer to your question: Why am I here?

I am here for two reasons: First, to review for you very briefly the aims of your medical Auxiliary, and secondly to ask your help.

Our two chief objectives, as stated in our Constitution, are to assist the State Medical Society of Wisconsin in its program for the advancement of medicine and public health, and to cultivate friendly relations among physicians' families.

In this age of auxiliaries, when every hospital, every profession, every business group, every labor union, even every volunteer fire department has an auxiliary, many of them competing with each other for the time and talents of busy wives and mothers, it is easy for any group to become enmeshed in a welter of projects and activities and to lose all contact with the parent organization.

This is a danger of all auxiliaries, and it is one that your medical Auxiliary wishes at all costs to avoid because, like it or not, an auxiliary is a public relations arm of the parent organization, be that organization the American Medical Association or Local 68 of the United Mine Workers.

We are your ambassadors in our church groups, in the PTA, at our bridge clubs, in the supermarkets. Everywhere women go, we represent you, and you must admit that we get around. And since we are your ambassadors, whether by design or no, it is our aim to be good ambassadors—to generate good will and understanding for the profession which in the eyes of the public we too help to represent. To do this it is vitally important that we be thoroughly informed so that when we speak for medicine we speak with knowledge and with conviction.

I won't take time to outline the projects we are engaged in this year; they have the approval of our Advisory Committee. I will save that part of the report for the annual meeting in the spring, when I will have this advantage: I will know which ones to brag about and which ones to gloss over because they fell flat.

As I stated, my second reason for speaking to you this afternoon is to ask for help in a project we have just begun. There are twenty counties in Wisconsin where there is no auxiliary to the Medical Society. For various reasons an organized auxiliary may not be feasible there at the present time; but there are still doctors' wives in those counties, and we would like to get to know them.

Some of them might like access to some of the information that the Auxiliary receives. Some might like to attend meetings of general interest, and we want to extend to them the invitation to become members-at-large.

To get the names of these wives we wrote to the secretaries of the societies in these counties, asking for a current membership list indicating those who are married. Out of twenty, ten replied, which put us well ahead of the Harris polls which figure that 30 per cent response is good.

If you represent one of the counties in which the secretary has not replied, will you do us a favor? Will you just nudge him a bit? Our letter probably got tucked away under some much more important reports.

And when our letter to the doctors' wives arrives, will you please understand its purpose? Of course we would like to see an auxiliary in each county; but the decision to organize must be made locally, on the basis of local conditions, local needs and local desires.

We would welcome new groups, but their formation must come at the request of the county society and of the wives of that county. Our purpose in writing is to reach the individual doctor's wife, to extend a friendly hand, and to invite her to be a member-at-large. We think she might like belonging to the Auxiliary branch of her husband's professional society.

So, would you say a good word for Auxiliary membership? And in counties where there is an auxiliary as well as where there is none, would you put in a word for us? We have only 53 per cent of our membership potential in Wisconsin, which on a national basis is good, but it leaves much room for improvement.

I would like to suggest also that while you are about it, you ask your wife the current status of her membership.

Thank you for letting me take your time. What the Auxiliary does may seem very unimportant in comparison to other matters that you have to consider, and really it is, except for one fact—that in the eyes of the public, your patients, we do help to represent the medical profession, and we think it is highly important that we represent you truly and that we represent you well.

Speaker Callan: The next report will be given by your president, Doctor Egan.

REPORT OF THE PRESIDENT

President W. J. Egan: I heartily endorse Mrs. James' plea that we should cooperate in every way we can, and that is why we have been glad to give part of our time to her to speak to us.

October 18 is a memorable day because it marks your pioneer midyear session. It is a particularly memorable day for me because on October 18, 1934, Red Grange came to fame. He made three touchdowns against us at Michigan in about five minutes. There were twelve doctors there watching. We looked for hotel rooms and there were none, so the twelve of us slept in cubbyholes in the barroom.

At five o'clock in the morning Doctor Kiley wandered into my cubbyhole and said, "I just got a call from your wife's obstetrician. You are the father of a baby daughter." My lovely third child, a daughter, has now given us six grandsons and three granddaughters, and she is working on three more to make a dozen.

On May 6, 1963, I spoke to this legislative body on the matter of constructive teamwork to improve our Society so that we can successfully meet the problems of organized medicine. Then, as now, these problems call for sound decisions to resolve the complex questions in the most medical statesman-like manner.

Then, as now (and I felt then as I feel now), physicians are most capable in management of socioeconomic affairs if they will be attentive, diligent and prudent in the art of persuasion which is the dominant factor that moves people to action.

Today, at the half-way point of my year as your president, I must report that although things are somewhat better in many ways, and that improvements have occurred in other areas, I am far from satisfied with our first half of this year. Many of the reasons for this feeling are or will become evident to you as this meeting goes along. For that reason I will not list the obvious reasons.

I earnestly hope that the last half of my term will provide a much happier verdict. The aura—the feeling—of contentiousness or contention has definitely lessened in our Society, but many members fear this may be only a lull in the storm. We still need definite improvement in all phases of our communications (that to me is our chief failure), written and oral.

You are all familiar with the bases of communication. You have talked about this and you have heard about it. "You must be precise, accurate," and so on. It should be non-propaganda in character. It should not have a bureaucratic content, and it must be given simultaneously to all responsible officers and members.

Many recognize the values in the good sending and good receiving in speaking and in listening.

There are many points that could be made here, cycle but too few people recognize the type of manners attendant upon communications. Good or bad manners are to me more indicative of the basic attitude of members than other phases of behavior.

There are many points that could be made here, but they will show up later today or tomorrow or the rest of the year. Permit me to submit a few thoughts for your consideration.

Bear in mind the futility of amending, passing or changing bylaws, rules or regulations when experience has clearly demonstrated that many of these orders are ignored, forgotten or definitely not followed out.

During this pioneer midyear meeting I suggest you give thought to ways and means of preventing a recurrence of such a situation as we have been faced with in the last few years.

I will speak for just a moment as an ex officio officer member of the Implementation Committee that you appointed last May. The Committee worked hard, to the point of exhaustion, and even though prodded by the Speaker and myself they met with a fatigue response. There are going to be several situations presented to you that will be awkward and that will have uncomfortable aspects, but they must be met head-on to reach a satisfactory solution, and you are familiar with them all the way through. I will enter the discussion or answer any questions you have.

I wish you great luck on this pioneer activity.

Vice-speaker Carey: Our next report will be from the Chairman of the Council, Doctor Fox.

REPORT OF THE COUNCIL

Dr. J. C. Fox [La Crosse]: As you know, you have already received the report of the Council in your House of Delegates Handbook. However, with your permission, at this time I will read to you a supplemental report of the Council which will be distributed to you for your further consideration.

The Council meeting last night, October 17, 1963, took the following actions to be reported to the House:

1. It gave final approval to an occupational health program for hospital employees, and copies will be made available to physicians as soon as possible.

2. There is a program on medicine and religion planned for the Wisconsin Work Week of Health. The Planning Committee, under the chairmanship of Dr. R. C. Frank, urges representatives of county medical societies to observe the program with the idea of using it as a format for meetings within their own area.

3. The Council unanimously approved a resolution to amend the Bylaws to provide for creation of a Scientific Fellowship. This reads as follows:

> *Resolved:* That Chapter VIII of the Bylaws be amended to create a new Section 6, renumbering present Sections 6 and 7.
>
> "Section 6. Scientific Fellows: The Council may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine, the status of Scientic Fellow. Scientific Fellows shall pay no dues or assessments, shall receive the WISCONSIN MEDICAL JOURNAL, and shall be eligible to attend scientific sessions of the Society.
>
> "By proper provision of the Constitution and Bylaws, either or both as may be necessary, a county society may create a similar classification."

COMMENT: This would extend the privileges of membership to *non-MD* teachers of the basic sciences, by Council election. They would have the right to attend meetings of the Society and to receive the WISCONSIN MEDICAL JOURNAL, but no right to vote or hold office. The fiscal impact of this amendment would be measured by the number conferred times the subscription rate for the WMJ at $6 per year.

4. A number of country medical societies, in the transition from one office to another, seem to have misplaced their Constitution and Bylaws, and as a consequence copies are not on file with the State Society. This may become important under a number of circumstances and leave the county society without the shelter of its own constitution and bylaws to protect its activities.

In light of these circumstances the Council has adopted a model constitution and bylaws and recommends to the House the following resolution:

> *Resolved:* That Section 1 of Chapter XI of the Bylaws be amended by the addition of the following sentence:
>
> "Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply."

This amendment has no fiscal implications.

5. The Council reports the following amendment to enlarge the Commission on Public Policy so that representation from the scientific sections may be included:

> *Resolved:* That Chapter VII, Section 4 of the Bylaws be amended to read as follows:
>
> "The Commission on Public Policy shall consist of seven representatives from the membership at large, a representative from each scientific section created under Chapter XIII, Section 1, the President, President-elect, and the Secretary. Representatives from the scientific sections shall be appointed by the President of the State Medical Society from a panel of three nominees submitted by each section; or in event of the failure of any section to submit nominees, the President may appoint a member from that specialty group. As nearly as possible the terms of one-third of the members representing the scientific sections shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one-, two- and three-year terms. Representatives from the membership at large shall be appointed pursuant to Section 1 of this Chapter. The Commission may elect its own executive committee of five members.
>
> "The Commission shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities."

Because there are divisions of medicine in which the various members of the State Medical Society possess a special interest, and because of the vast amount of public policy which affects these divisions, individually as well as collectively, Chapter VII, Section 4 is amended to provide for representation

from the scientific sections on the Commission on Public Policy.

The predictable costs incurred would be those connected with meeting functions, and this would involve a nominal increase.

6. The Council records its agreement with a policy statement of the Wisconsin Hospital Association opposing legislation which would make it mandatory that a governmental agency be responsible for the franchising of new or expanded hospital facilities. The Council further agrees with a statement of the Trustees of the Wisconsin Hospital Association that voluntary efforts be directed toward area planning, and believes these should be utilized to the fullest extent possible

7. The Committee on Economic Medicine, under the chairmanship of Dr. E. J. Nordby, has reported to the Council that there is currently being studied a pension plan for Society members providing another choice in addition to the recently announced AMA plan, and further study must be carried on before the Council is able to offer a firm recommendation.

8. In other actions, the Council received for information material of the Joint Commission on Pharmacy and Medicine organized by the AMA and composed of representatives of both medical and pharmaceutical professions.

The Committee on Clinical Medicine has been designated to meet with the Wisconsin Nurses Association to formulate a statement relative to external cardiac massage.

A conference will be held late in the year or early next year to consider the possibility of organizing an Association of the Professions. This has been established in Michigan with what appears to be a high degree of success.

The Executive Committee of the Charitable, Educational and Scientific Foundation has reported that it has directed a change of the fiscal year to coincide with that of the State Medical Society and that has been accepted by the Council. Matters relating to staff implementation of Foundation activities will be given further study.

The Wisconsin Health Council, Inc., an organization of which the State Medical Society is a charter member, is investigating the possibility of holding a series of regional conferences in Wisconsin on rural health. This is an important project, and the Wisconsin Health Council offers an ideal vehicle through which to achieve the development of these conferences. The Council agreed with the Society's Commission on Public Relations and Communications to support and participate in such conferences if they come about.

On recommendation of the Commission on Medical Care Plans, the Council transmits to the House two resolutions, one in commendation of the passage of Kerr–Mills implementing legislation during 1963, and a further resolution which is self explanatory. They are attached to this report.

Finally, the Council transmits a special report on out-of-state meetings which is attached for your information.

RESOLUTION

Introduced by: Commission on Medical Care Plans

WHEREAS, Wisconsin has implemented the Kerr–Mills law by passing Chapter 163 of Wisconsin Statutes, known as the Health Assistance Payments Act; and

WHEREAS, The Health Assistance Payments Act (HAPA) provides for Wisconsin one of the finest medical assistance plans for the aging in the nation; and

WHEREAS, More than 175,000 Wisconsin citizens over age 65 will be eligible for medical care benefits under this program; and

WHEREAS, The law is designed to meet the needs of the individual, and assures him free choice of physicians and hospital; therefore be it

Resolved, That the House of Delegates of the State Medical Society of Wisconsin strongly commend the bi-partisan support of the Wisconsin Legislature and Governor in implementing this fine program of medical assistance for the aging.

RESOLUTION

Introduced by: Commission on Medical Care Plans

WHEREAS, Wisconsin has now enacted the Health Assistance Payments Act (HAPA) which permits implementation of the federal Kerr–Mills law in this state; and

WHEREAS, The importance of this law, and its administration, to public health in Wisconsin is fully acknowledged, and in that connection the State Medical Society has established a nonprofit service program known as Wisconsin Health Service to aid in its implementation, should that opportunity be afforded the State Medical Society; and

WHEREAS, The Wisconsin law provides benefits not only in the area of hospital and medical-surgical services, but also dentistry, pharmacy, and others; now therefore be it

Resolved, That the Council is authorized to add to the directing body of Wisconsin Health Service representatives of allied and ancillary professions to advise with it in direction of efforts in this field.

SPECIAL REPORT ON OUT-OF-STATE MEETINGS

On some occasions, very few in number, the Council and certain committees of the Council have met in Chicago and in the Twin Cities. There has been some comment directed to the fact that the Council, the Executive Committee, and the Commission on Medical Care Plans have met outside of the state.

The reasons for doing so should be made importantly clear to the House. To further its own knowledge of the inner workings of the American Medical Association, the Council had the pleasure of meeting in its headquarters and having presented to it in excellent format various topics of every day importance to the medical profession. Department heads of the AMA gave generously of their time, and the details of operations and policies of the AMA were thoroughly and carefully explained. The Council was sufficiently impressed by the value of this occasion that it authorized the holding of the annual conference of presidents and other officers of county medical societies also in Chicago, in the auditorium of the AMA, in 1962.

We feel this has done much, in many ways to solidify support in those areas in which the AMA is the one effective organization to represent American medicine. Our own delegates to the AMA offered a resolution to its House which was adopted urging other state medical societies to find ways to engage in such a worth-while opportunity.

Wisconsin is one of the six states which belongs to the North Central Conference, the others being Iowa, Nebraska, North and South Dakota, and Minnesota. This group of states organized an annual program conference for officials of each of the state societies many years ago. It became so successful that from it developed the national Conference of State Presidents and other officials, holding its meetings at least once a year. However, the six states who originally founded the conference felt the need, and appropriately so, to reorganize their group limited to these six. Because of its cen-

tral location, the Twin Cities have been accepted as the annual meeting place. Each state pays nominal dues to finance the program, but Minnesota as the host state furnishes all secretarial assistance and assumes the responsibility for planning the details. Out of the activities of these six states many contributions have been made in the affairs of medicine nationally. Here was the birthplace, for example, of the Washington office of the AMA; and here, for another example, was the action taken which ultimately led to the organization of the Council on Medical Service of the AMA.

On two occasions the Council has been called into session in the Twin Cities at the time of the North Central Conference. It has conducted official affairs of the State Medical Society on a Friday evening and Saturday morning, and on occasion Saturday evening. Members of the Council and Officers stay for the Sunday program and by this device your Council and Officers have had opportunity to draw strength from other states, their interest in Wisconsin and Wisconsin's interest in them.

The demands on Councilors and Officers, particularly as to time, are quite tremendous. The cost of meeting in Chicago or in the Twin Cities is about the same as meeting in the western part of Wisconsin or in Milwaukee. The conservation of time and energy, however, is an important consideration and from time to time in the future some similar occasions may arise when the Council, in exercise of its judgment, may find it again desirable to meet in the Twin Cities or have its Executive Committee do so, or again meet with the board of trustees of the AMA.

It is true also that the Council and the Commission on Medical Care Plans have held meetings in the northern part of the state in recognition of the fact that while we constantly ask physicians from the northern half of the state to come to the southern half, there should be at least one occasion a year when those groups that meet with frequency recognize the sacrifice in time of those who for the most part are always coming to Madison or to Milwaukee. All of these sessions are working sessions.

Vice-speaker Carey: The next report is that of our secretary, Mr. Crownhart.

REPORT OF THE SECRETARY

Secretary C. H. Crownhart: Members of the House of Delegates, I think I will defer my report until tomorrow morning in the event the reference committee can't complete their work in time for the 10:30 a.m. part of the meeting.

At a recent meeting of the Finance Committee of the Council, and by direction of the Council, it was decided to make available to everyone in the room the certified public audits of the State Medical Society of Wisconsin.

There has been some comment that we are a complex organization, and that is true. I might add also that I find the medical profession very complex too, and sometimes I have a little difficulty with my own profession, because we do live in a complex society and we have many and varied interests.

Mr. John B. White, a member of the firm of Donald E. Gill & Company, will go through the audit with you—I trust with a fair degree of speed—and will be available to answer any questions any of you may have after this session is over or before the Resolutions Committee.

Audit Report

Mr. John B. White: While these reports are being passed out to you, let me say first of all that this report is the regular report of your Certified Public Accountants and, as Mr. Crownhart said, is customarily given to your Finance Committee.

Your Certified Public Accountants engage primarily in two functions—auditing the accounts of the Society, its divisions and related organizations, and consulting on matters of program and policy when requested in areas in which our judgment is applicable. The report I am making to you now is in this first area, that of audits.

I think perhaps some of you may be slightly appalled at the prospect of going through this volume. It is not my intention that we go through it page by page; there is not sufficient time, and that would be rather dull. It would fail to accomplish the objective which we have in mind. This objective is to create for you a sense of perspective on the financial structure of your Society.

I want to just highlight significant information, and round off figures so that you can understand them more easily and see how they relate to each other. Mr. Crownhart mentions questions which you may undoubtedly have. There will be an opportunity for you to present them and for us to answer them.

Let me just lay the general framework in which we ought to look at this report. Your Society, as you know, the State Medical Society of Wisconsin, is a corporation. Within its corporate structure are four divisions. We refer to one as the General Fund. This is essentially the area of operations financed primarily from dues. Second, the Medical Journal, publishing your scientific journal. Third, Wisconsin Physicians Service, which operates the medical care plans of the Society. Fourth, Medicare, care referring to medical care for dependents of military personnel.

These four operations are within the corporate structure. Outside your corporate structure are three others—SMS Realty Corporation, a corporation holding title to this real estate; the Charitable Foundation, separately incorporated, which operates medically-oriented charitable, educational and scientific activities; and an employees' pension plan set up to provide a retirement program for Society employees.

With your participation and cooperation let's take a look at each one of these. If you will turn to your larger book and turn to tab No. 2, in this report on page 2, this is the General Fund, the Fund in which dues of members are the primary financial consideration.

You will notice on page 2, about the center of the page, total assets of $189,000 as of December 3, 1962. Looking up that column, note that most of these are current assets—$154,000. Notice also that most of the current assets seem to be cash—about $135,000. It is rather unusual that the Society at the end of a year has cash in this amount. Let's see why this should be.

If you look down to the bottom of the page, note that the special assessment, unexpended funds at last December 31, amounted to $42,000. Dues of some members for 1963 had been prepaid as of December 31—$23,000. Looking up under Current Liabilities, Payroll and Property Taxes, 1962 taxes payable promptly after the end of the year, $22,000. These three alone amount to $87,000, accounting in large part for this amount of cash at December 31.

We have looked at these liabilities. Let's turn to the next page, page 3. You will see the net worth of your General Fund as at December 31, 1962, was $88,000. We ought to know just a little more about this, and I would like you to turn to page 11 in this report and let's see what is in this net worth.

One part is the part of it devoted to fixed assets—that is, furniture and equipment of the Society's General Fund. The Section on Medical History within the Society collects dues and pays out some of it for its operations. This much is remaining and is part of the net worth relating to that Section.

In current surplus, then, we have three parts—$16,000 representing working capital advanced to the Medical Journal for its operations, about $5,000 appropriated for the 1963 budget, and unappropriated surplus of about $59,000. As we will see in just a minute, this amounts to approximately two months' operating expenses. It is working capital to assure a continuing operation of these activities.

Now let's turn back to page 4 and see something about the income and expense of this General Fund. As we stated, the major element of income is members' dues—$300,000 out of $332,000. Annual meeting income is significant here. This is offset by direct costs of the annual meeting in May.

Looking at expenses, $322,000 in total, note the payroll, $129,000, and just below that $12,000 for related item of taxes and employee benefits. Together with conference expenses, the second item in the list, of $25,000, these three amount to $166,000 or about one-half of the total. In a service organization such as this, this is a normal relationship.

Note also that $10,000 of expenses are subtracted here. The reason for this is that at times the activities of the General Fund are devoted to operations outside the General Fund. In such cases a charge is made to the outside operation, and for that reason these expenses are subtracted here and are charged to the other operation division where it may belong.

Excess of income over expense last year was almost $10,000. We saw a moment ago that $5,000 of this is reserved for the 1963 budget. The remaining $5,000 is approximately 2 per cent of total income.

At the bottom of this page the transactions in the Special Assessment Fund are set out separately. During 1962 $82,000 was collected, $40,000 was spent, and there remained $42,000 to carry into 1963.

Now let's turn to tab No. 3, and we can do this very quickly. This is the Medical Journal. It is devoted exclusively to the publication of your Journal. Page 3, if you will, is the balance sheet. Total assets are $22,000. Again, most of these are current. The $19,000 of current assets represents basically working capital for the continuing operation of the Journal.

Liabilities are normal payables. The capital of the Journal is $16,000, exactly the same figure which is shown in the General Fund as working capital advanced for the Journal.

Let's turn for a moment to the next page, to what is entitled Exhibit B at the top, and here we see the income and expense of the Journal. Income is primarily advertising income, $47,000, and an appropriation from the General Fund of $3,000 representing an offset to costs of putting into the Journal those pages in which the Society reports to you many of its business affairs.

Under Expenses, the major item is printing, $38,000 as direct cost. The next item, $7,000, is payroll related to putting the Journal together. The $1,500 loss at the bottom represents approximately 3 per cent of total income. A non-profit organization, when it tries to shoot exactly for the line, may sometimes miss it a little but under as well as a little bit over.

Turning to tab No. 4, the third division within the corporate structure, Wisconsin Physicians Service. Turn again to page 2. This is the largest dollar area among these divisions. May I ask you first to turn to page 4; then we can kind of get an idea of what we are talking about when we say it is the largest dollar-volume area.

In 1962 earned premiums were $11,000,000. Of these, the cost of benefits incurred and charged against these premiums, 9–½ million dollars, or 86 per cent, leaving about $1,600,000 for expenses and addition to reserves.

Now, if you will please turn to page 2, let's see where the assets and liabilities are. As of December 31, 1962, total assets were about 5–½ million dollars. Current assets, $4,600,000. The largest item here, current investments about $3,800,000, primarily U. S. Government securities. Cash of $363,000 is a minimal balance because cash is kept as low as possible in order to have funds available to meet continuing payments of benefits. Those paid in January 1963 were $793,000, and then to invest as much as possible. Premiums receivable is a fairly steady balance and represents amounts billed primarily for coverage in the succeeding months.

Under Long-term Assets the major item, $572,000, is mortgage notes receivable, most of which were receivable from SMS Realty Corporation, as we shall see.

Wisconsin Physicians Service advances $100,000 to the Medicare operation as a working capital advance.

Under Liabilities, we see current liabilities relatively small in amount except for one. $1,600,000 is a liability for the cost of benefits incurred at or before December 31, 1962, but not paid on that date and payable in 1963. It is by the nature of operations necessary to estimate a portion of this liability, and this is done on a continuing basis.

Turning the page to page 3, another class of liabilities is Deferred Income. We collect premiums in advance of the time they are earned. Until they are earned we must defer them and show this $1,300,000 as a liability.

Total reserves, about 2–½ million at December 31, 1962. These reserves are still less than a desired rule of thumb for reserves, which is three months' benefit expense and operating expense. This is a goal toward which plans of this sort strive.

You will note that the new income over expenses in 1962 increased reserves by $426,000. If you will turn to page 21, near the end of this report, we will see exactly where that came from and how it was developed.

Again you will see that the premiums after payment of benefits incurred were $1,600,000. At the bottom of the page you see $1,322,000 for expenses. Look up one-third of the way and you will see that payroll was $707,000 of this. Again, a significant part of the expenses and a normal relationship under the rule of thumb for service organizations such as this.

Turning the page, we again subtract expenses incurred by Wisconsin Physicians Service but devoted to other operations, in this case primarily Medicare operations. Again from operations of $276,000 is 2.5 per cent of those premiums we saw before. There was investment income of $150,000, which then brings about the $426,000 added to reserves, as we saw a moment ago.

Coming to the fourth one within the corporate structure, Medicare, and again turning to page 2, this balance sheet is slightly different from the others, in that there is no net worth here. Total assets and total liabilities are identical. Assets represent cash and reimbursements receivable from the government for claims paid to physicians. Liabilities represent current expenses and the $100,000 advanced from Wisconsin Physicians Service.

Turning one more page, to page 3, you will notice also that income and expenses are identical. Income is the reimbursement of the expenses incurred. Under this program, operating expenses chargeable to it are billed directly and reimbursed directly rather than on any basis of quoted rate per claim.

We are better than half-way through. We have gone through those items in the corporate structure of the Society. I think you can begin to see the need

for the separation of these accounts into separate sets of books.

Now let's turn to tab No. 6, which shows us the first of our organizations outside the corporate structure. This is SMS Realty Corporation, a separate corporation. It holds title to the real estate used by the Society, and is exempt from income tax under a special section of the Internal Revenue Code for organizations of this nature.

The basic pattern of the realty corporation is to set up a budget for operation of the building and the services that are used in it. In this preparation of a budget the item of repairs is handled on a long-range basis; that is, over a period of years repairs will average a certain amount per year, rather than show a minimal amount in early years and a large amount in later years, which would unduly burden a rental budget. This is leveled off.

The amount developed from this budget is pro rated between the General Fund and Wisconsin Physicians Service on the basis of how the space in the building is used. This space cost has been reviewed by a real estate consultant and compared with commercial rentals for similar rentable property in the area. The technique and method of allocating costs and developing this budget is reviewed every year by our firm.

In this tabulation, and again on page 2, we see the balance sheet of SMS Realty Corporation at the close of last year. Total assets were $831,000, and the largest item here is not current assets but rather it is fixed assets. $771,000 is the largest group of fixed assets in any of the sets of reports at which we are looking.

Under Liabilities, you will note a liability in part for current construction; the $23,000, the last figure on the page. This relates to amounts payable in construction of this wing of the building in which we are located now.

Under Long-term Liabilities, $560,000 represents the mortgage loans payable to Wisconsin Physicians Service.

Looking at net worth on the second page of our balance sheet, it is essentially in three parts. The first part is capital contributed by the State Medical Society of Wisconsin, $150,000. Certain property has been donated to the realty corporation. Its value is $3,300. Reserves, about $60,000, are detailed at the bottom of this page and at the right in the last column.

The reserve for repairs and maintenance is developed, as I was mentioning a while ago, because on a level budgeting basis when repairs are light in early years a reserve is accumulated out of which heavier repairs in later years may be met.

The reserve for return on investment is a reserve out of funds in the budget which serve as a cushion or protection so that the realty corporation may continue to meet the growing needs of the Society, its tenant, as years go by.

A reserve for funding appreciation takes into account the fact that, generally speaking, in these days when an asset wears out and is replaced, the new one costs more than the old one. This reserve will provide funds which will make it possible, then, to replace an asset which may have such a higher cost.

If we turn to page 4 we see income and expense of the realty corporation for 1962. The major item, of course, is rent, $120,000. Cafeteria income, $21,364.38, and is identical with cafeteria expense. In other words, this is a break-even operation. The cafeteria operation is something you will see before you leave the building this week end. The point to remember, however, is that it is not a money-making or money-losing proposition to the realty corporation.

The three types of expenses—those of operating the building, of furnishing the services, and of administration—are shown in more detail if we turn to the very last page in this report, page 16. The second column, the last figure, cafeteria expense, the same as the income figure we noted earlier, $21,364.38.

In the first column, Building Operation, these are expenses usual to operation of a building—heat, light, taxes, depreciation of assets, cost of personnel to keep the building operating. Services are essentially the services of telephone service—that is, the switchboard, the switchboard operators, and the charges for the local service.

In the last column, Administration, the major item is interest on indebtedness. Other items—cost of legal and accounting services, the internal accounting costs, payroll taxes, and so on. These, then, make up the total expenses of SMS Realty Corporation.

Tab No. 8 is the Employees Pension Plan. You will notice that on page 2 our balance sheet shows total assets of $147,000. Most of these assets are securities, and these are shown here at their market value because, under terms of the plan, securities are revalued at the close of each year.

A small liability existed, and net worth or principal of this plan was $147,000.

You might be interested in knowing that the plan has as participants in 1963 thirty-nine employees of the Society. This principal is allocated to accounts of the participating employees and is built up in part from contributions made by the employees as well as the employer.

Looking at the bottom part of this page, during 1962 contributions of the employer totaled $19,000; those of employees, $7,000, and a further item increasing the fund was its net income for the year of about $3,400.

Let's skip the next two pages and turn to page 4. We see here how this fund has income from principally dividends and interest on its investment. During the year, because we revalued securities, we sustained a loss in market values of approximately $1,000. $500 was the cost of investment counsel. The Society retains investment counsel, and they advise both Wisconsin Physicians Service and the Pension Plan on the nature of its investments, making suggestions as funds are available for investment.

Before closing this book I only want to point out to you that tab No. 9 is a report of the Student Loan Fund Trust. This Trust still exists, but its operations were taken over some time ago by the Charitable Foundation because it operates the Student Loan Program. It is necessary to regard this Trust as still in existence.

Tab No. 10 is a summary of insurance coverage.

Let me refer you briefly to tab No. 1, in which all of these statements are consolidated. We won't take the time to look at them at this point, however.

We skipped one tab in the middle, and that was the Charitable Foundation. The reason we did so is that it has continued to have until this year a fiscal year ending June 30. You have a separate book, found in the gray cover, in which the June 30 report of the Foundation is shown. Incidentally, the Foundation has changed its fiscal year now to December 31, and this then will be in line with all other activities of the Society.

The Foundation is a corporation. It is exempt from income tax under a separate section of the Internal Revenue Code for organizations like it, and it is designed in this way so that it may attract tax-deductible contributions to carry on its activities. It has taken over the program of student loans from the former Trust.

Shown here are (left to right) Dr. J. C. Griffith, Milwaukee, chairman of the Management Survey Study Committee; Dr. R. E. Callan, Milwaukee, speaker; and Dr. W. J. Egan, Milwaukee, president of the State Medical Society.

Let's look again at page 2 in this report for just a moment. Total assets of the Foundation on June 30 were $306,000. The largest item is fixed assets, which is made up almost entirely of the physical property at the Museum of Medical Progress in Prairie du Chien. Long-term assets are $133,000 and are made up principally of student loans, $86,000, and of funds invested, $40,000 and $5,000. These funds are invested because they were contributed with the request that they be invested and that income from this invested principal be used.

Looking up a little farther, cash of $29,000 consists in part of working capital and in part of contributions made for special purposes, special projects not yet activated.

If we turn the page, liabilities are the current ones for current expenses. A long-term liability of $50,000 for mortgage notes payable on construction of buildings at the Museum of Medical Progress. The Foundation's capital at June 30 was almost $250,000. Almost 80 per cent of it was restricted capital—that is, restricted for specific projects—while the balance was unrestricted.

Now, if we close this book (and we have already closed the other) we have completed our guided tour through the financial structure of the Society. Behind this total picture is an awful lot of financial activity with a program. The Society operates a multitude of transactions generated and recorded, and the results of them are shown in the reports we have submitted to you today.

In our reports we say in our letter that we want to express our appreciation for the courteous assistance furnished by those with whom we came into contact. I would like to express my appreciation to you for your courteous help and cooperation.

Another thing you will find in our reports is our unqualified opinion on each one of these sets of records. In our opinion the reports you have present fairly your Society's financial condition and its operations for the dates and periods given.

Dr. Ernest Strakosch [Oshkosh]: I would like to congratulate the firm and Mr. White for presenting this, but most of all I want to express my appreciation to the Administration which made this report possible. This is the first time that all of us have seen the financial structure of the Society. Some of us who have tried to delve into it and find out what is going on, found nothing available.

I think this is a great step forward. The moral of this story is that if one lives long enough, progress is accomplished. This is a sign of progress.

Speaker Callan: The House will now hear the report of the chairman of the Special Study Committee, Dr. Joseph C. Griffith.

[This report appears on page 527 of this issue.]

Speaker Callan: I will announce at this time the referral of reports to the reference committees. Where the subject matter is related, your Speaker has made every effort to refer those matters to the same committee.

To the Reference Committee on Reports of Officers:

Report of the Council.

Supplemental report of the Council except three proposed Bylaw amendments and two resolutions of the Commission on Medical Care Plans.

Report of the Executive Committee of the Foundation.

Commission on State Departments.

To the Reference Committee on Reports of Standing Committees:

Public Policy Report.

Special Report on Bill 134, A.

Commission on Scientific Medicine.

To the Reference Committee on Resolutions

Dues for 1964.

Financial Report.

Resolutions 1 through 4.

Survey Report and Resolutions 5 through 14.

Report of the Commission on Medical Care Plans.

Two resolutions and three Bylaws amendments from the Supplemental Report of the Council.

It is a privilege as well as an opportunity for any interested member of the Society to appear before these committees and present his views on any matter properly before them. Delegates who are interested in any particular matter are especially urged to be present.

All delegates have been reminded by the Secretary's office of that provision of the Bylaws providing that all new business first introduced at this time must be introduced through the Council, constitutional officers, committees of the Society or of the House, or officers of the House.

[The meeting adjourned at 4:20 p.m.]

SATURDAY MORNING SESSION

October 19, 1963

The second session of the House of Delegates convened at 9:30 a.m., Dr. R. E. Callan, Speaker, presiding.

Vice-Speaker Carey: The first report is that of the Credentials Committee. Will Doctor Carlson please report.

Doctor Carlson: The Committee on Credentials has verified the registration of 64 delegates and 10 alternate delegates entitled to vote at this session of the House of Delegates.

Also, the Credentials Committee has been informed that the following will act as delegate for the regular delegate and alternate who are unable to attend:

George Parke, MD, for Richland County
John Kreher, MD, for Ashland–Bayfield–Iron Counties
G. W. Dean, MD, for Milwaukee County
P. B. Blanchard, MD, for Ozaukee County
L. F. Gulbrandsen, MD, for Vernon County
R. E. Roethke, MD, for Milwaukee County

I move that the attendance roll of delegates, alternates and specially appointed delegates, totaling 74, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

[Motion seconded and carried.]

Vice-Speaker Carey: The next order of business is the reports of reference committees of the House. The first reference committee to report is the Reference Committee on Reports of Officers. Will Doctor Bolger please report?

REPORTS OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

Dr. J. V. Bolger [Milwaukee]: Your Reference Committee on Reports of Officers presents the following report:

1. Your Committee has reviewed the report of the Council. We move to accept this report and applaud the Council's efforts in establishing the various institutes for the betterment of public and personal relationships with the programs and fields allied with medicine.

[Motion seconded and carried.]

2. The Supplemental Report of the Council has been reviewed with the exception of the three resolutions to amend the Bylaws and the two resolutions introduced by the Commission on Medical Care Plans. This contained a special report on out-of-state meetings, and this Committee feels that though these activities be taxing to the time and energy of the participants, we feel they should be continued as long as they are in the best interests of the State Medical Society.

The Reference Committee recommends that the Supplemental Report of the Council be adopted.

[Motion seconded and carried.]

3. Your Committee has reviewed the report of the Executive Committee of the Charitable, Educational and Scientific Foundation. We feel that the work this committee has done has been outstanding in the projects it has fostered and carried through to completion. We would urge the State Medical Society to continue encouraging physicians of the State to participate in the projects of this Foundation and to be financially contributing members as well.

The Committee recommends adoption of this portion of the report.

[Motion seconded and carried.]

4. The report of the Commission on State Departments has been reviewed by this Committee, and we recommend that it be adopted.

[Motion seconded and carried.]

5. The report of the Division on Aging was also reviewed, and your Committee recommends that it be adopted.

[Motion seconded and carried.]

6. The Committee has reviewed the report of the Division on Nervous and Mental Diseases. In reviewing the various activities throughout the State in the area of mental health, we would urge the State Medical Society to make every effort to gain physician membership on any State committees representing mental health. The State Society should likewise encourage physician participation through their county medical societies in cooperating with local programs and in developing community activity in the promotion of voluntary services for the elderly.

Your Committee recommends that this report be adopted.

[Motion seconded and carried.]

7. The Committee also reviewed the report of the Division on Public Assistance, and it is felt that those matters concerning county welfare departments should be handled at the local level. We encourage each county medical society to have an interest in and active liaison with its county welfare department. We recommend that the Division continue its efforts to have State departments utilize other terminology than "medical care" to reflect the cost of total health care.

Shown is the Reference Committee on Reports of Officers: (left to right) Dr. F. M. Hilpert, Racine; Dr. C. J. Strang, Barron; Dr. M. V. Overman, Neillsville; Dr. James V. Balger, Milwaukee; and Dr. H. F. Twelmeyer, Wauwatosa.

Your Committee recommends adoption of this report.

[Motion seconded and carried.]

8. The Committee reviewed the report of the Division on Handicapped Children and we recommend adoption of this report. This Division is to be complimented on the review of its programs and the services offered, but we would have it be vigilant and cognizant of the fact that their activities should be curtailed as the need for them diminishes.

[Motion seconded and carried.]

I now move the adoption of the report of the Reference Committee on Reports of Officers as a whole.

[Motion seconded and carried.]

Vice-speaker Carey: The next reference committee to report is the Reference Committee on Reports of Standing Committees. Doctor Gehin, will you please report?

REPORT OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

Dr. F. E. Gehin [Stevens Point]: Your Reference Committee on Reports of Standing Committees has reviewed the report of the Commission on Public Policy and again wishes to commend the Commission for its diligent work throughout the partly completed legislative session. This refers in particular to the success in passage of the Wisconsin Public Health Assistance Act for Kerr–Mills implementation, which was hailed as one of the notable legislative achievements of the Society in the past quarter-century.

We also concur with the Commission in its views in relation to optometry, chiropractic, and podiatry.

We call your particular attention to Bill 107 S. which would add the subjects of bacteriology, biochemistry and hygiene to the basic science requirements, and urge that members of the Society back this bill, since proficiency in the basic sciences is essential for the best patient care.

The Committee also endorses the Commission's opposition to Bills 627 and 628 A, which would subject all Blue Plans to detailed regulations by the Insurance Commissioner, including the setting of rates.

In regard to mental health, it would seem premature for the Legislature to take final action without more thorough and detailed analysis by appropriate committees or advisory groups, since there are twenty or more bills dealing with revision of the Mental Health Act.

Shown is the Reference Committee on Reports of Standing Committees: (left to right) Dr. J. E. Martin, Jr., Delavan; Dr. F. E. Gehin, chairman, Stevens Point; Dr. D. R. Griffith, Milwaukee; Dr. W. T. Russell, Sun Prairie; and Dr. G. W. Hilliard, Milwaukee.

This Committee endorses the amendment to Bill 492 A, removing physicians and dentists from regulatory authority of the State Board of Health in setting standards for hospitals.

I move acceptance of this portion of the report.

[Motion seconded and carried.]

Your Committee has also reviewed the special report of the Commission on Public Policy and the Ophthalmologic Legislative Committee, and heartily endorses the activity of the Section on Ophthalmology in regard to Bill 134 A.

This bill must be defeated in the interest of the public welfare, and legislators must be given knowledge to permit them to understand the actual goals of this legislation. Lack of training must be explained to the public, as must the difference between a trade with a limited license and a profession trained to render total patient care. The medical profession is the one group equipped to expose the critical defects and inherent dangers, and protect the public's interest by opposing this badly conceived piece of legislation.

Delegates are urged to make themselves aware of all legislation affecting medicine and public health, and to make their feelings known to their county medical societies, and they in turn to members of the Legislature.

I wish to add here that we commend the Commission on Public Policy for working with special group interests on their Commission, such as was shown by this report from the Ophthalmologic Legislative Committee. Each delegate is strongly urged to re-read the report and bring it to the attention of their county medical society and fellow practitioners.

I move acceptance of this portion of the report.

[Motion seconded and carried.]

Your Committee has reviewed the report of the Commission on Scientific Medicine and wishes to commend it for its continued efforts at diversification in order to present educational programs of interest and value to the entire medical profession. Recent inovations include experiments in educational television and teaching programs utilizing "visiting professors," both in cooperation with our two medical schools. We also commend the Editorial Board of the WISCONSIN MEDICAL JOURNAL for establishing procedures for an annual writing award and for medical photography exhibits.

I move acceptance of this portion of the report.

[Motion seconded and carried.]

I now move adoption of this report as a whole.

[Motion seconded and carried.]

Speaker Callan: The report of the Reference Committee on Resolutions and Amendments to the Constitution and Bylaws is just about completed. There are only a few mimeographed copies available at the moment. In order to expedite the proceedings we will proceed slowly until you all have copies in your hands.

The Chair would remind the delegates to keep the reference committees' reports and to mark the actions taken by the House so that they will have a record of the transactions of the House to transmit to their county medical society members, because it will be a few weeks before the summary of the transactions can be sent out to the delegates.

The last reference committee to report is that on Resolutions and Amendments to the Constitution and Bylaws. The members of this Committee are: Drs. T. J. Nereim, Madison, chairman; E. P. Rhode, Galesville; G. A. Behnke, Kaukauna; L. E. Fazen, Jr., Racine; G. E. Collentine, Jr., Milwaukee; L. W. Schrank, Waupun, and C. J. Picard, Superior. Doctor Nereim, will you please report?

REPORT OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

Dr. T. J. Nereim [Madison]: Your Reference Committee on Resolutions has carefully considered all matters referred to it and makes the following report:

It wishes to commend the Administration for presenting the audit report, and recommends distribution of a moderately condensed financial report annually to the chairman of each county delegation, the members of the Council, and members of the Reference Committee on Resolutions.

[Motion seconded and carried.]

Your Reference Committee considered Resolution Nos. 1 and 2, introduced by the Fond du Lac County Medical Society, regarding "Relationship with the State Welfare Department" and "Insurance Coverage for Medical Care of Relief and Welfare Recipients" at the same time, since the subject matters were related.

It is recommended that these two resolutions be referred to the Council for further study, and that the results of such study be reported at the next meeting of the House.

[Motion seconded and carried.]

Resolution No. 3 was also introduced by Fond du Lac County and urged further efforts to standardize insurance forms and reports. Your Reference Committee recommends approval of the resolution as submitted.

[Motion seconded and carried.]

The La Crosse County Medical Society introduced Resolution No. 4, inviting the State Medical Society to hold its annual meeting in La Crosse in 1965 or 1966. We recommend rejection of this resolution as we feel it appears to be impractical at this time.

[Motion seconded and carried.]

Resolution No. 5, introduced by the Management Survey Study Committee, is concerned with an interim session of the House. It is recommended that the Resolved clause call for amendment to the Bylaws only, and as amended would read:

"*Resolved:* That Chapter III, Section 1 of the Bylaws be amended by adding the same sentence used by the AMA: 'The House of Delegates shall hold one interim session each year.'"

Your Reference Committee introduces this resolution for action next May.

[Motion seconded and carried.]

Your Committee recommends that Resolution No. 6, also introduced by the Management Survey Study Committee, be amended and approved as follows:

"*Resolved:* That the House of Delegates, at its fall meeting, receive, consider and act upon the programs of the Society and their supporting budgets for the ensuing year; and be it further

"*Resolved:* That this material be sent to the delegates three weeks prior to said meeting."

[Motion seconded and carried.]

Resolution No. 7, introduced by the Management Survey Study Committee, reads:

"*Resolved:* That the fiscal year of all organizations of the Society commence on January 1 and extend through December 31."

Your Committee recommends approval as submitted.

[Motion seconded and carried.]

The Management Survey Study Committee introduced Resolution No. 8. Your Reference Committee wishes to recommend approval, with the addition of a time limit, so that it would read as follows:

"*Resolved:* That the Council receive annual reports and recommendations for new programs from the chairmen of all committees sufficiently in advance of the fall meeting to permit the Program Planning and Budget Committees to make accurate appraisals and recommendations to the House of Delegates three weeks prior to the fall meeting."

[Motion seconded.]

Speaker Callan: Doctor Nereim, you have amended the original resolution. Will you please explain how the resolution was amended, so that we can vote on the amendment and then on the motion as amended?

Dr. G. E. Collentine, Jr. [Milwaukee]: A point of order, Mr. Speaker. I don't believe it is necessary for the House to vote on any amendment that is incorporated into a resolution offered by the Reference Committee on Resolutions.

Speaker Callan: Your point of order is well taken.

[Motion carried.]

Doctor Nereim: Your Reference Committee wishes to recommend Resolution No. 9, introduced by the Management Survey Study Committee, as written:

"*Resolved:* That all appointments to the Committees of the Council shall be made at the organizational meeting of the Council which shall be held immediately following the annual meeting."

[Motion seconded and carried.]

Your Reference Committee recommends approval of Resolution No. 10 as submitted. This reads:

"*Resolved:* That reports of all committees be available to the Council at least six weeks before the meeting of the House of Delegates to which they are to be submitted."

[Motion seconded and carried.]

Your Committee recommends Resolution No. 11 in the following amended form:

"WHEREAS, there should be a consistent policy regarding reimbursement of members for expenses necessarily incurred in attending meetings of the Society; now, therefore, be it

Resolved: That the Council shall establish a policy concerning reimbursable expense items of councilors, officers and committee members, and shall report this policy to the House of Delegates for action at its next meeting."

[Motion seconded and carried.]

Your Reference Committee on Resolutions has considered Resolution No. 12, having to do with the Blue Plans, and the majority feels that the Survey Committee has failed to substantiate its statement that merger of the Blue Plans is "impractical and untimely," and recommends that the Survey Committee prepare a more detailed analysis of that portion of the Booz, Allen and Hamilton report having to do with reorganization of the Blue Plans, for submission to the next meeting of the House of Delegates.

Mr. Speaker, we have a minority report to submit at this time.

Speaker Callan: Who will present the minority report?

Doctor Nereim: First may I move adoption of the majority report.

[Motion seconded.]

Speaker Callan: A minority report has been prepared and Doctor Schrank will present it.

Dr. L. W. Schrank [Waupun]: The minority feels that Resolution No. 12 as introduced by the Management Survey Study Committee should be adopted.

I move that this minority report be substituted in place of the majority report. This minority report is signed by myself and Dr. C. J. Picard.

Speaker Callan: At this time Mr. Crownhart, secretary of the Society, asks for the floor.

Secretary Crownhart: I listened to the discussions yesterday at length, and they were philosophical and historical, and it was hard to disagree with many of the views that were presented. But there was one matter not presented before this House in discussion of the report of the Committee, and that was the administrative side of operating an economic arm in behalf of a Society policy.

Blue Shield of Wisconsin, Blue Shield of Milwaukee, Blue Cross, are tremendous organizations. Their income is large; their plans are long; their history is well known to you, and they stand as a symbol of the endeavors of the medical profession and the endeavors of the hospitals to provide voluntary insurance in lieu of compulsory health insurance.

The State Medical Society and its long record in the matter of voluntary insurance has never endorsed what would be a monopolistic approach. It has said, as has the parent body, the American Medical Association, that the voluntary way is the American way. So, your philosophy is neither governmental medicine nor is it monopolistic medicine. It is voluntary insurance.

Both Blue Shield plans, even though they compete, represent that type of endeavor, as does Blue Cross, and this House stands on record as approving Blue Cross.

As we commit ourselves, no matter by what plan, to the provision of benefits for years to come, almost, when we say to the people of this State, "You will be entitled to the benefits of major illness pro-

tection that may run over a period of many months and up to limits quite high, such as $10,000," we aren't committing ourselves to a program of the moment, not in the economic sense. Under the special service contract, where benefits may run again as high as $10,000 under WPS, we are not committing ourselves to a benefit or a contract protection of a week or a month or a year from now because once these benefits are earned by the subscriber he is entitled to the umbrella which he purchased when he was well.

I think it has been hard for all of us to live in a competitive situation in which there is talk of merger, and talk of dissolution, and talk of getting out of the insurance business because, while that talk goes on, we are endeavoring to convince the people that the voluntary way is the American way.

We have a staff here of 175 people who are now working on the various technical phases of that insurance. Our programs, Blue Cross and Wisconsin Physicians Service, cover the employees of the State of Wisconsin, and they cover many reputable organizations that are committed to living and competing in the atmosphere of Wisconsin.

A month hence there will be a conference in this room at which there will be over 150 in attendance representing Blue Cross, Surgical Care, Wisconsin Physicians Service, voluntary insurance companies; and the theme of that conference will be: How can we extend voluntary insurance? How can we improve it? How can we make the people aware that when they have the protection of voluntary insurance that is their assurance that they will not be dominated in their health needs by governmental programs?

The Secretary at times, and on limited occasions, and seldom after sitting in a meeting until four o'clock in the morning, does address himself to the policy of the State Medical Society. I do not think you would wish it otherwise. While I am not in agreement entirely with some of the phrasing, I recommend that you adopt the minority report.

Speaker Callan: The motion is made and seconded to substitute the minority report for the majority report. Is there further discussion?

Dr. P. B. Blanchard [Cedarburg]: I second the minority report.

Speaker Callan: The motion is to substitute the minority report or to back the original recommendation of the Survey Committee, and to substitute that for the majority report, which is to be referred back to the Survey Committee. Further discussion?

Dr. H. M. Suckle [Madison]: I wonder if we can have a recess for caucus?

Speaker Callan: I think that would be very appropriate. Would ten minutes be sufficient?

Dr. R. L. Beilman [Madison]: Is the minority report identical to the recommendation in the Survey?

Doctor Schrank: The Survey Study Committee, yes.

[Recess for caucus.]

Speaker Callan: May I have your attention, please? Have all the voting delegates and alternate delegates registered this morning for this present session?

Now may we have the supplemental report of the Credentials Committee.

Doctor Carlson: In addition to those delegates already registered and reported by the Credentials Committee, six delegates have registered and are entitled to vote.

I move that this attendance roll of delegates, alternate delegates and specially appointed delegates, totaling 80, so compiled by the Credentials Committee, be accepted as the official roll of this session of the House.

[Motion seconded and carried.]

Speaker Callan: The motion before you is to substitute the minority report for the majority report

Doctor Collentine: I would like to take this opportunity to express my personal gratification, and, by recommendation of the Milwaukee County delegation, its gratitude at the attitude of objectivity, soberness and good will in which the discussions have been carried on so far; and for myself for the manner in which the discussions were carried on at the Reference Committee meeting last night, in public session and in executive session. I believe this is in such striking contrast to the climate of five years ago that it is worthy of mention.

I move an amendment to the substitute motion as follows: I move that the Resolved portion of Resolution No. 12 be amended in the second line, to insert the phrase after the word 'Service': "The Blue Shield Plan of the State Medical Society of Wisconsin . . . and be it further

> "*Resolved:* That the Survey Committee be instructed to prepare a more detailed analysis of that portion of the Booz, Allen and Hamilton report having to do with reorganization of the Blue Plans, for submission to the next meeting of the House of Delegates."

The Milwaukee County delegation would favor this minority report as amended.

Voice: Will you read the new resolution?

Doctor Collentine: "*Resolved:* That Wisconsin Physicians Service, the Blue Shield Plan of the State Medical Society of Wisconsin, and Surgical Care, the Blue Shield Plan of the Medical Society of Milwaukee County, continue to operate independently under their present structure, and that each operate throughout the State under fair competition; and be it further

"*Resolved:* That the Survey Committee be instructed to prepare a more detailed analysis of that portion of the Booz, Allen and Hamilton report having to do with reorganization of the Blue Plans, for submission to the next meeting of the House of Delegates."

I move the amendment to the substitute resolution.

[Motion seconded.]

Speaker Callan: Is there discussion of the amendment to the substitute resolution?

Dr. R. N. Allin [Madison]: The minority report recommends acceptance of Resolution No. 12 as prepared by the Survey Study Committee. If you accept that resolution as written, I think there is a conflict. If you check part 4 of the insurance programs referring to merger of the insurance programs, it says that this should be rejected in all parts.

Speaker Callan: Are you talking about the plan of action, Doctor?

Doctor Allin: Yes, that's right.

Speaker Callan: That was for the information of the delegates that the special Study Committee had considered each one of these points. It is not a resolution in itself. Is that right, Mr. Chairman of the Special Study Committee?

Doctor Griffith: That is correct.

Speaker Callan: It has no binding on this House of Delegates. It is just a checklist for all the delegates to see that every item in the Booz, Allen and Hamilton report was considered.

The Reference Committee on Resolutions and Amendments is shown: Right: (left to right) Dr. T. J. Nereim, Madison, chairman; Dr. E. P. Rhode, Galesville; Dr. G. A. Behnke, Kaukauna; and Dr. L. W. Schrank, Waupun.

Below: (left to right) Dr. L. E. Fazen, Jr., Racine; Dr. C. J. Picard, Superior; and Dr. G. E. Collentine, Jr., Milwaukee.

Doctor Allin: Then it does not mean that if you accept this resolution, as Doctor Collentine has recommended, you are closing the door for further study regarding merger of the two Plans?

Speaker Callan: It is my interpretation that it does not close the door. The plan of action is strictly for the information of the delegates as to the extent of the Survey Committee's activities.

Doctor Allin: All right.

Speaker Callan: Do I express that correctly, Doctor Griffith?

Doctor Griffith: That is correct.

Dr. J. W. McRoberts [Sheboygan]: Is the Survey Committee willing to accept that?

Speaker Callan: I think they will. I can only say that it has been inspiring to see these men spend all this time on it, and I am sure their motivations have been of the highest. After all these long hours and meeting for the fourth session on a Sunday morning, it comes time to meet and every member is there. It has been something to participate in. It has been drudgery, but it is for the betterment of the Society, and I am sure they will continue.

Dr. J. J. Voytek [Ft. Atkinson]: Being relatively new to the Society, I have been instructed by my county society as to what I am supposed to do and not to do at this particular meeting.

Speaker Callan: Are you speaking relevant to the amendment?

Doctor Voytek: Yes. As every county society probably has had meetings relative to the Booz, Allen and Hamilton report, our Society had a number of them relative to each of the phases that were outlined. I was given instructions as to how I should react, and, if possible, voice an opinion.

My Society or the members of the County Society feel that anything that has been so argumentative and disputed, and so on, over a period of time, since it requires the combined action of all the members of the State Society—that perhaps a complete elucidation of the facts, the ability or the inability of the two organizations to get together to iron out their differences about the merger—if all of this were presented to the societies for an evaluation, we could approach the next meeting and voice a definite opinion of the members of our societies. I have been instructed to so state my intent to vote for my county. They do not want me to vote on this until they themselves have had an opportunity to instruct me.

Speaker Callan: You then are supporting the amendment to refer this back for additional study and more detailed information, and report at the next session.

Doctor Voytek: Right, sir. If it is possible to send a supplemental report out between now and May to the county societies for evaluation, maybe we can resolve this in May.

Speaker Callan: Is there any other discussion on the proposed amendments to the minority report? The two amendments clarify the identity of the State Medical Society, Wisconsin Physicians Service, as a Blue Shield Plan, and the other is an amendment asking for a more detailed analysis of that portion of the Booz, Allen and Hamilton report having to do with the reorganization of the Blue Plans, to be submitted at the next meeting.

Do you wish to consider these amendments together, or separately? Is there any other discussion?

All those in favor of the proposed amendments to the minority report, signify by saying "aye"—

Dr. Howard Mauthe (Section on Radiology); On the amendment proposed by Doctor Collentine to the minority report, and that's all?

Speaker Callan: Yes.

Dr. R. A. Straughn [Madison]: I ask for a roll call vote on the amendment.

Speaker Callan: I am in no position to decide. It is the will of the assembly.

Doctor Strakosch: Have a voice vote first.

Doctor Bolger: I should like to ask Doctor Collentine why he feels an amalgamation of these two ideas would be advantageous.

Doctor Collentine: I think the feeling was expressed frequently enough last night that Resolution No. 12 as presented might be interpreted as the will of the House to discourage further negotiation toward the achievement of more harmony between the Plans, and that adoption of this amendment leaving the door open for further study and, as I have said, a more detailed analysis of the Booz, Al-

len and Hamilton report, as requested by Walworth County, would provide further information for the delegates and the membership, explaining why we are not flatly favoring adoption of the Booz, Allen and Hamilton recommendation or flatly rejecting it.

Doctor Strakosch: Doctor Collentine, in what respect does your amendment differ basically and philosophically from the recommendation of the Reference Committee?

Doctor Collentine: From the majority report?

Doctor Strakosch: Yes. The majority report said, "Let's put this back in the Committee, and study and talk more about it." From now on things can get awfully clouded and technical, and I am getting very confused.

Doctor Collentine: Well, if you want to call it a spade, call it a spade, Doctor Strakosch. Resolution No. 12 rescinds the action of Stevens Point by implication, and we consider this a major step forward in the restoration of harmony in the State Society by giving permission for what the Medical Society of Milwaukee County is continuing to do, and considers itself legally entitled to do, and at the same time it calls for further education of the delegates and the membership as to reasons why that status should be changed—if it should be changed.

Doctor Strakosch: But in what way? I am glad you brought this out, for this was hidden under the table. Now it is at least on the table. In what way does your attitude differ from the recommendation of the Resolutions Committee? In a way that we tacitly agree that Milwaukee County now can go out and assign without any recommendation; is that right?

Doctor Collentine: Yes.

Doctor Strakosch: Thank you.

Speaker Callan: Is there any further discussion of the proposed amendment?

Dr. M. V. Overman [Neillsville]: I am really happy that Doctor Collentine got up and made an amendment in favor of the resolution practically as the majority group has requested, and I think it really is a big step forward. I for one would feel that we should all go along with and keep it open. There may be some very good things come from settling it in a business-like manner. [Applause]

Speaker Callan: Are you ready for the question? The question is the adoption of the proposed amendments to the minority report. Do you understand the amendments? One amendment is to identify WPS as a Blue Shield Plan. The other amendment is to have it say: *Resolved:* That a more detailed analysis of that portion of the Booz, Allen and Hamilton report having to do with reorganization of the Blue Plans be submitted to the next meeting of the House of Delegates by this Special Survey Committee.

Doctor Allin: Would Doctor Schrank or Doctor Picard read the entire resolution together with this amendment so it is clear to everybody just what we are voting on?

Speaker Callan: Doctor Schrank, will you do so, please?

Doctor Schrank: The resolution—this is the entire resolution, not just the amendment to the minority report.

Speaker Callan: This is the entire amended minority report that, if carried, would be substituted.

Doctor Schrank:

"*Resolved:* That the Wisconsin Physicians Service, the Blue Shield Plan of the State Medical Society of Wisconsin, and Surgical Care, the Blue Shield Plan of the Medical Society of Milwaukee County, continue to operate independently under their present structure, and that each operate throughout the State under fair competition; and be it further

"*Resolved:* That the Survey Committee be instructed to prepare a more detailed analysis of that portion of the Booz, Allen and Hamilton report having to do with reorganization of the Blue Plans, for submission to the next meeting of the House of Delegates."

Dr. E. J. Nordby [Madison]: I would like to speak to a point of order.

I am wondering, and asking for information, and not speaking to the subject itself, whether it is possible for a member of the Committee signing the majority report to submit an amendment to that report.

Speaker Callan: There are signatures to several items in the Resolutions Committee report. It would appear to the Speaker that if the Chairman of the Resolutions Committee was notified by members of his Committee that these members wish to object to a certain portion—a small portion—of that report, with the clear understanding that that would be done, that would be perfectly appropriate.

If the members of the Resolutions Committee, in the Speaker's opinion, objected to the report as a whole, then of course he should not sign the report. Formally, perhaps, he could have made a notation on the margin of the report that he didn't agree with a certain portion of the report. The Speaker feels this is a technicality.

Dr. E. L. Bernhart [Milwaukee]: I think that eliminates further debate and discussion. Let's have the question and vote.

Doctor Straughn: May I discuss the motion? Before we vote on this amendment, because I think it is very vital, I think it is most important that Doctor Collentine clarify it. If we do not vote for the amendment we are then able to go back to the majority report, which really includes the amendment—

[Cries of "No!"]

Doctor Straughn [continuing]: Yes, it does. "Your Reference Committee on Resolutions has considered Resolution No. 12, having to do with the Blue Plans, and the majority feels that the Survey Committee has failed to substantiate its statement that merger of the Blue Plans is 'impractical and mittee prepare a more detailed analysis of that untimely,' and recommends that the Survey Comportion of the Booz, Allen and Hamilton report having to do with reorganization of the Blue Plans, for submission to the next meeting of the House of Delegates."

My point is that if we vote against the amendment and against the minority report we will end up by having the amendment added to the majority report. It is already written in there.

Speaker Callan: May the Speaker ask Doctor Collentine to clarify once more the reason for adding the amendment to the minority report.

Doctor Bernhart: May I interrupt with a point of order. Has my suggestion been taken? I haven't had an answer to it.

Speaker Callan: The Speaker interpreted that as an informal question, that you were ready to vote. It was not a formal motion that debate be ended and a two-thirds vote be taken to close debate.

Doctor Collentine: I do ask that before a vote is taken on the amendment, you clarify for the benefit of myself and the House the exact steps that will be taken on amendment, on substitute resolution, and on majority resolution.

Again I have been asked to repeat: There were those who felt that Resolution No. 12 as offered

could be interpreted as expressing the will of the House that the status quo be maintained, and that further negotiation be discouraged, or further consideration of negotiation be discouraged. Therefore, in addition to passing a resolution that both Blue Shield plans continue to operate as they are now harmoniously and successfully doing, that the Survey Committee return to the House with a more detailed analysis of the Booz, Allen and Hamilton report which will be for the education of the House and the membership by way of explaining why we did not adopt the widely publicized confidential recommendations of the Booz, Allen and Hamilton report, or why we did not flatly reject them.

Speaker Callan: The procedure for deciding this issue, in the Speaker's opinion, is this: The amendments to the minority report will be voted on first. Then the motion to substitute the minority report as amended for that portion of the majority report will be in order. If it is substituted then it will be voted on once more to carry. Does everybody understand it?

Are you ready for the question? The motion is on the adoption of the amendments to the minority report. All those in favor, signify by saying "aye;" opposed, "no." All those in favor, please stand. The Chair is no longer in doubt. The amendments to the minority report are adopted.

Now we will consider the substitution of the minority report, as amended, for that part of the majority report that is pertinent.

Dr. F. E. Drew [Milwaukee]: I so move.

[Motion seconded.]

Speaker Callan: All those in favor of substituting the amended minority report for the majority report, signify by saying "aye;" those opposed, "no." Those in favor, please rise. The Chair feels that the "ayes" have it. However, on such an important issue, if the assembly would request a roll call vote, I think it would be appropriate. We want to settle these things fairly and clearly, without any repercussions.

Doctor Strakosch: I move that a roll call vote be taken. Not that I question the accuracy of the count, but I think we should be on record for future discussion so we know who did what, with what, to whom. [Laughter]

Speaker Callan: There is a motion and a second that a roll call vote be taken. All those in favor, say "aye;" opposed, "no." Will those who voted "no" please stand.

Doctor Suckle: You have to take a roll call vote. A motion is not necessary. We have to have a roll call vote.

Speaker Callan: You are correct. The Secretary will call the roll and tabulate the vote.

Secretary Crownhart: Those voting "aye" are voting for the adoption of the minority report as amended.

Speaker Callan: The Chair has decided that there shall be a roll call vote on the substitution of the amended minority report for that section of the majority report that is appropriate.

Mr. Crownhart will call the roll. Those in favor of substituting the amended minority report will say "aye;" anybody objecting, of course, will say "no."

A roll call vote was taken and the tabulation was as follows:

Society	Delegates and Alternates	Yes	No
Ashland–Bayfield–Iron	John Kreher		x
Barron–Washburn–Sawyer–Burnett	C. J. Strang	x	
Brown	Donel Sullivan		x
Calumet			
Chippewa	M. W. Asplund		x
Clark			
Columbia–Marquette			
Adams	R. T. Cooney		x
Crawford			
Dane	Robert L. Beilman	x	
	T. J. Nereim	x	
	R. N. Allin	x	
	N. M. Clausen	x	
	H. M. Suckle	x	
	A. P. Schoenenberger	x	
	W. T. Russell	x	
	R. A. Straughn		x
Dodge	L. W. Schrank	x	
Door–Kewaunee	D. E. Dorchester	x	
Douglas	C. J. Picard		x
Eau Claire–Dunn–Pepin	D. R. Griffith	x	
	A. A. Drescher	x	
Fond du Lac	D. J. Twohig, Jr.		x
Forest			
Grant	C. L. Steidinger	x	
Green	R. G. Zach	x	
Green Lake–Waushara			
Iowa	W. D. Hamlin	x	
Jefferson	J. J. Voytek	x	
Juneau			
Kenosha	R. W. Ashley	x	
La Crosse	G. B. Murphy, Jr.		x
	D. L. Morris		x
Lafayette			
Langlade			
Lincoln	R. J. Henderson	x	
Manitowoc	T. H. Rees	x	
Marathon	E. P. Ludwig	x	
Marinette–Florence	J. W. Boren, Jr.	x	
Milwaukee	W. L. Coffey	x	
	E. L. Bernhart	x	
	D. J. Carlson	x	
	R. A. Nimz	x	
	E. D. Wilkinson	x	
	G. E. Collentine, Jr.	x	
	E. G. Collins	x	
	W. J. Conen	x	
	F. E. Drew	x	
	A. E. Roethke	x	
	G. W. Hilliard	x	
	H. M. Klopf	x	
	P. E. Oberbreckling	x	
	R. Laubenheimer	x	
	F. A. Ross	x	
	D. M. Ruch	x	
	A. J. Sanfelippo	x	
	C. M. Schroeder	x	
	H. F. Twelmeyer	x	
	G. W. Dean	x	
Monroe			
Oconto			
Oneida–Vilas	Marvin Wright	x	
Outagamie	G. A. Behnke		x
	J. W. Bergwall	x	
Ozaukee	P. B. Blanchard	x	
Pierce–St. Croix	C. A. Olson	x	
Polk	L. O. Simenstad	x	
Portage	F. E. Gehin	x	
Price–Taylor	R. E. Nystrum	x	
Racine	L. E. Fazen, Jr.	x	
	G. L. Rothenmaier	x	
Richland			
Rock	M. F. Purdy	x	
	D. M. Clark	x	
Rusk			
Sauk			
Shawano			

Society	Delegates and Alternates	Yes	No
Sheboygan	J. W. McRoberts	x	
Trempealeau-Jackson-Buffalo	E. P. Rohde		x
Vernon			
Walworth	J. E. Martin, Jr.	x	
Washington	E. C. Quackenbush	x	
Waukesha	J. V. Bolger, Jr.		x
	Robert Monk	x	
Waupaca			
Winnebago	H. J. Colgan		x
	E. A. Strakosch	x	
Wood	E. C. Glenn	x	
Section on			
Dermatology	Joel Taxman	x	
General Practice	R. R. Richards	x	
Internal Medicine			
Neurology-Psychiatry			
Obstetrics-Gynecology	D. O. Price	x	
Ophthalmology-Otolaryngology	R. T. Schmidt	x	
Orthopedics			
Pathology			
Pediatrics			
Public Health	G. M. Shinners	x	
Radiology	Howard Mauthe	x	
Surgery	J. A. Killins	x	
Urology	F. M. Hilpert	x	

Speaker Callan: The Speaker has unofficially counted 13 "noes." The amended minority report has now been substituted for this portion of the majority report, and this is the report you are now voting on. Are you ready for the question? All those in favor, signify by saying "aye;" those opposed, "no". We don't need a roll call. It is carried.

The amended minority report has been substituted for that portion of the majority report and has been adopted.

Doctor Nereim, will you please continue with your report.

Doctor Nereim: Your Reference Committee recommends acknowledgement of Resolution No. 13 having to do with calling a special meeting of the House, and recommends presentation at the annual meeting of the House of Delegates in May, 1965, amended as follows:

"*Resolved:* That Article VIII, Section 3 of the Constitution of the State Medical Society of Wisconsin be amended by striking out the present Section 3 of Article VIII and substituting the following Section:

"Section 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10 per cent or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for which the session is called, and the session shall consider no business except that for which it is called."

[Motion seconded and carried.]

Your Committee recommends that Resolution No. 14, relating to creation of the position of Historian, be referred back to the Survey Committee for fiscal note and resubmission to the House at the next meeting.

[Motion seconded and carried.]

Your Committee recommends acceptance of the introduction portion of the report of the Survey Study Committee read by Chairman Griffith, and recommends further that the Committee be continued for another full year, and that the Committee be commended for its diligent efforts.

The Committee considered the section entitled "Recommendations of the Survey Study Committee on the Booz, Allen and Hamilton Report," and anticipates resolutions implementing them in May.

[Motion seconded.]

Doctor Strakosch: Do you mean a year from now? Starting now? It says "be continued for another full year." Starting when?

Speaker Callan: The Chairman of the Resolutions Committee says it is intended for a full year, as printed. That would mean from now. Is there further discussion?

[Motion carried.]

Doctor Nereim: Your Committee considered the three Bylaw amendments proposed by the Council relating to Scientific Fellows, county society constitution and bylaws, and enlargement of the Commission on Public Policy. We recommend acknowledgement of receipt of these resolutions for submission to the House at the annual meeting in 1964.

[Motion seconded and carried.]

Your Committee recommends approval of the two resolutions in the supplemental report of the Council, introduced by the Commission on Medical Care Plans, and relating to commendation of the Legislature for passage of Kerr-Mills implementing legislation, and expansion of the membership of Wisconsin Health Service.

Your Committee recommends that the report of the Commission on Medical Care Plans be accepted.

Finally, your Committee recommends that dues for 1964 remain unchanged.

I now move the adoption of the report of the Reference Committee on Resolutions as a whole.

[Motion seconded.]

Doctor Allin: I just want to clarify a point. In accepting the report of the Survey Study Committee, what do you mean by the introductory part? Does that mean that you are agreeing that all sections that have been either approved, modified, accepted or rejected—that you are accepting the report on those parts of the Survey they have rejected for further study? Is that what we are doing here?

Speaker Callan: Could you help us out, Doctor, by showing us what you mean?

Doctor Allin: The report of the Survey Study Committee. Is that the report you are passing on?

Speaker Callan: Is that the report read by Doctor Griffith?

Doctor Allin: This is their original report.

Speaker Callan: That is this two-page report. The report in question is the report by Doctor Griffith, the report of the Survey Study Committee, and on the second page are the names of the members of that Committee. Do you all have that in your kits?

Doctor Allin: Is that what you are referring to?

Speaker Callan: Yes.

Doctor Allin: By your action you have then approved their decision to reject certain parts of the report; is that correct?

Speaker Callan: There is nothing in this that calls for any rejection. It is more of a report of the activities of the Committee, and in the final

paragraph it says that the work has not been done, and they request permission of the House to continue for another year.

I think the point of confusion is the other several pages, called "Recommendations of the Special Survey Committee," and there are page numbers on the side. That has not been considered. We are not accepting that.

Doctor Allin: It appeared that this was the covering report that involved the details that you have there, that have been acted on, passed or modified or rejected.

Speaker Callan: The Chair rules that the question of information was on the formal report of the activities of the Survey Study Committee, by Doctor Griffith, and that the other report is not being considered.

The motion is made and seconded for adoption of the Resolutions Committee's report as a whole, as amended. Is there any discussion?

[Motion carried.]

Speaker Callan: Is there further business?

Secretary Crownhart: The Secretary, in a facetious sense, reports a "no." We can never predict exactly when you will begin, and you can see how we can never predict when we are going to stop a meeting. At about twelve o'clock there will be 125 box lunches down in the dining room. That is where they are probably going to stay. Thank you all very much for your cooperation.

Doctor Bernhart: I would like to make a comment. I would like to compliment the House in total and the Chairman for the splendid meeting we have had. Being a delegate to the AMA, I am going to go to the interim meeting and tell them that our house is now in order.

Thank you so much. [Applause]

Speaker Callan: Our President reminds the membership and delegates to help this Committee in any way they can. Communications are the very lifeline of our organization. We hope we are on the right road.

Doctor Strakosch: I move we adjourn.

[Motion severally seconded and carried.]

[Meeting adjourned sine die at 11:15 a.m.]

ATTENDANCE AT HOUSE OF DELEGATES

	Sessions 1	Sessions 2
SOCIETY:		
Ashland—Bayfield—Iron		
John Kreher, Ashland	x	x
Barron—Washburn—Sawyer—Burnett		
C. J. Strang, Barron	x	x
Robert Anderson, Cumberland	o	o
Brown		
B. P. Waldkirch, De Pere	o	o
Donel Sullivan, Green Bay	x	x
J. L. Ford, Green Bay	o	o
L. H. Edelblute, Green Bay	x	x
Calumet		
E. W. Humke, Chilton	o	o
A. C. Engel, New Holstein	o	o
Chippewa		
M. W. Asplund, Bloomer	x	x
J. J. Sazama, Chippewa Falls	o	o
Clark		
M. V. Overman, Neillsville	x	x
R. L. Hansen, Colby	o	o
Columbia—Marquette—Adams		
R. R. Rueckert, Portage	x	o
R. T. Cooney, Portage	x	x
Crawford		
M. S. Garrity, Prairie du Chien	x	o
T. F. Farrell, Prairie du Chien	o	o
Dane		
R. L. Beilman, Madison	x	x
F. D. Bernard, Madison	o	o
T. J. Nereim, Madison	x	x
K. L. Siebecker, Madison	x	x
R. N. Allin, Madison	x	x
A. J. Richtsmeier, Madison	x	o
N. M. Clausen, Madison	x	x
R. P. Sinaiko, Madison	o	o
H. M. Suckle, Madison	x	x
A. E. Cowle, Madison	o	o
A. P. Schoenenberger, Madison	x	x
P. B. Golden, Madison	o	o
W. T. Russell, Sun Prairie	x	x
G. J. Derus, Madison	o	o
R. A. Straughn, Madison	x	x
G. E. Oosterhous, Madison	o	o
Dodge		
L. W. Schrank, Waupun	x	x
R. E. Urbanek, Beaver Dam	x	x
Door—Kewaunee		
W. G. Sheets, Sturgeon Bay	o	o
D. E. Dorchester, Sturgeon Bay	x	x
Douglas		
C. J. Picard, Superior	x	x
R. P. Fruehauf, Superior	o	o
Eau Claire—Dunn—Pepin		
D. R. Griffith, Eau Claire	x	x
G. G. Giffen, Eau Claire	o	o
A. A. Drescher, Menomonie	x	x
W. R. Manz, Eau Claire	o	o
Fond du Lac		
D. J. Twohig, Jr., Fond du Lac	x	x
W. E. Myers, Fond du Lac	x	o
Forest		
E. F. Castaldo, Laona	o	o
B. S. Rathert, Crandon	o	o
Grant		
H. W. Carey, Lancaster	x	x
C. L. Steidinger, Platteville	x	x
Green		
R. G. Zach, Monroe	x	x
W. J. Staab, Jr., Monroe	o	o
Green Lake—Waushara		
C. A. Klasinski, Wautoma	o	o
David Sievers, Berlin	o	o
Iowa		
W. D. Hamlin, Mineral Point	x	x
S. B. Marshall, Hollandale	o	o
Jefferson		
J. J. Voytek, Fort Atkinson	o	x
R. R. Liebenow, Lake Mills	o	o
Juneau		
J. S. Strong, Mauston	o	o
M. S. Tverberg, Mauston	o	o
Kenosha		
R. W. Ashley, Kenosha	x	x
G. C. Schulte, Kenosha	o	o
La Crosse		
G. B. Murphy, Jr., La Crosse	x	x
F. H. Wolf, La Crosse	o	o
D. L. Morris, West Salem	x	x
G. E. Skemp, La Crosse	o	o

First name is delegate, indented name is alternate. x—present, o—absent.

	Sessions 1	Sessions 2
Lafayette		
R. E. Oertley, Darlington	o	o
L. J. Unterholzner, Blanchardville	x	o
Langlade		
W. P. Curran, Antigo	x	x
D. W. Dailey, Elcho	o	o
Lincoln		
R. J. Henderson, Tomahawk	x	x
J. F. Bigalow, Merrill	o	x
Manitowoc		
T. H. Rees, Manitowoc	x	x
W. F. Smejkal, Manitowoc	x	x
Marathon		
E. P. Ludwig, Wausau	x	x
A. H. Stahmer, Wausau	o	o
Marinette—Florence		
J. W. Boren, Jr., Marinette	x	x
C. E. Koepp, Marinette	o	o
Milwaukee		
V. L. Baker, Milwaukee	o	o
R. T. Sproule, Milwaukee	o	o
N. G. Bauch, Milwaukee	x	o
W. L. Coffey, Milwaukee	x	x
E. L. Bernhart, Milwaukee	x	x
L. E. Rothman, Milwaukee	o	o
D. J. Carlson, Milwaukee	x	x
R. B. Pittelkow, Milwaukee	o	o
J. F. Cary, Milwaukee	o	o
R. A. Nimz, Milwaukee	x	x
E. D. Wilkinson, West Allis	x	x
Rex Ruppa, Milwaukee	x	o
G. E. Collentine, Jr., Milwaukee	x	x
John Bareta, Milwaukee	x	o
E. G. Collins, West Allis	x	x
F. J. Millen, Milwaukee	o	o
W. J. Conen, Milwaukee	x	x
E. J. Schmidt, Wauwatosa	o	o
F. E. Drew, Milwaukee	x	x
P. G. LaBissoniere, Milwaukee	o	o
Edgar End, Milwaukee	x	o
Norbert Enzer	o	o
R. H. Lillie, Milwaukee	o	o
G. W. Hilliard, Milwaukee	x	x
T. F. Jennings, Milwaukee	o	o
G. S. Kilkenny, Milwaukee	x	o
R. J. Snartemo, Milwaukee	o	o
H. M. Klopf, Milwaukee	x	x
B. J. Peters, Milwaukee	o	o
H. J. Lee, Milwaukee	o	o
W. H. Frackelton, Milwaukee	o	o
George Murphy, South Milwaukee	o	o
R. H. Frederick, West Allis	o	o
P. E. Oberbreckling, Milwaukee	x	x
A. E. Roethke, Milwaukee	x	x
R. F. Purtell, Milwaukee	o	o
Roger Laubenheimer, Milwaukee	x	x
F. A. Ross, Milwaukee	x	x
T. J. Cox, Milwaukee	x	x
D. M. Ruch, Milwaukee	x	x
K. A. Liefert, Wauwatosa	o	o
A. J. Sanfelippo, Milwaukee	x	x
J. R. O'Connell, Milwaukee	o	o
C. M. Schroeder, Milwaukee	x	x
K. E. Sauter, Milwaukee	o	o
H. F. Twelmeyer, Wauwatosa	x	x
D. W. Calvy, Milwaukee	o	o
G. W. Dean, Milwaukee	x	x
S. E. Zawodny, Milwaukee	o	o
J. R. Evrard, Milwaukee	o	o
Monroe		
C. B. Koch, Lisbon	o	o
R. G. Konicek, Tomah	o	o
Oconto		
G. R. Sandgren, Suring	o	o
J. R. Culver, Oconto Falls	o	o

	Sessions 1	Sessions 2
Oneida—Vilas		
Marvin Wright, Rhinelander	x	x
L. L. Jacobson, Eagle River	o	o
Outagamie		
G. A. Behnke, Kaukauna	o	x
J. H. Russell, Appleton	o	o
J. G. Bergwall, Hortonville	x	x
W. H. Hale, Appleton	o	o
Ozaukee		
P. B. Blanchard, Cedarburg	x	x
Pierce—St. Croix		
C. A. Olson, Baldwin	x	x
Walter Orlow	x	x
Polk		
L. O. Simenstad, Osceola	x	x
R. M. Moore, Frederick	o	o
Portage		
F. E. Gehin, Stevens Point	x	x
A. J. Sowka, Stevens Point	o	o
Price—Taylor		
L. E. Nystrum, Medford	x	x
W. W. Meyer, Medford	o	o
Racine		
L. E. Fazen, Jr., Racine	x	x
V. J. Burch, Racine	o	o
G. L. Rothenmaier, Racine	x	x
W. F. Henken, Racine	o	o
Richland		
George Parke, Richland Center	x	o
Rock		
M. F. Purdy, Janesville	x	x
M. J. Roesler, Janesville	x	x
D. M. Clark, Beloit	x	x
J. C. Beltran, Beloit	o	o
Rusk		
H. F. Pagel, Ladysmith	x	o
M. L. Whalen, Bruce	o	o
Sauk		
E. V. Stadel, Reedsburg	o	o
J. A. Tibbitts, Reedsburg	o	o
Shawano		
D. A. Jeffries, Shawano	x	o
H. F. Laufenburg, Shawano	o	o
Sheboygan		
J. W. McRoberts, Sheboygan	x	x
D. M. Rowe, Kohler	o	o
Trempealeau—Jackson—Buffalo		
E. P. Rohde, Galesville	x	x
W. E. Wright, Mondovi	o	x
Vernon		
L. F. Gulbrandsen, Viroqua	x	x
Walworth		
J. E. Martin, Jr., Delavan	x	x
R. S. Galgano, Delavan	o	o
Washington		
E. C. Quackenbush, Hartford	x	x
W. A. Nielson, West Bend	o	o
Waukesha		
J. V. Bolger, Jr., Waukesha	x	x
Clarence Samuelson, Hartland	o	o
Robert Monk, Waukesha	o	x
Loren Driscoll, Oconomowoc	o	o
Waupaca		
O. E. Larson, Clintonville	o	o
M. O. Boudry, Waupaca	o	o

	Sessions 1	Sessions 2
Winnebago		
C. G. Kirchgeorg, Neenah	o	o
H. J. Colgan, Neenah	x	x
E. A. Strakosch, Oshkosh	x	x
S. J. Graiewski, Oshkosh	o	o
Wood		
E. C. Glenn, Wisconsin Rapids	x	x
W. B. Larkin, Marshfield	o	o
SECTION:		
Dermatology		
Joel Taxman, Milwaukee	x	x
James Bringe, Sheboygan	o	o
General Practice		
R. R. Richards, Eau Claire	x	x
J. A. Kelble, Milwaukee	o	o
Internal Medicine		
L. J. Kurten, Racine	o	o
R. L. Gilbert, La Crosse	o	o
Neurology—Psychiatry		
K. M. Keane, Appleton	o	o
R. E. O'Connor, Madison	x	x
Obstetrics—Gynecology		
D. O. Price, Madison	x	x
Ophthalmology—Otolaryngology		
R. T. Schmidt, Green Bay	x	x
F. G. Treskow, Milwaukee	o	o
Orthopedics		
J. O. D. McCabe, Milwaukee	o	o
John Van Driest, Sheboygan	o	o
Pathology		
J. L. Teresi, Milwaukee	o	o
L. M. Kleppe, Beloit	o	o
Pediatrics		
K. J. Winters, Wauwatosa	o	o
Richard Myers, Green Bay	o	o
Public Health		
G. M. Shinners, Green Bay	x	x
E. E. Bertolaet, Milwaukee	o	o
Radiology		
Howard Mauthe, Racine	x	x
L. E. Jones, Racine	o	o
Surgery		
J. A. Killins, Green Bay	x	x
A. G. Martin, Milwaukee	o	o
Urology		
F. M. Hilpert, Racine	x	x
A. J. Jacobsen, Racine	o	o

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin.

1. **Interprofessional Code**
   An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

2. **Guide to The Service Corporation Law**
   A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

3. **Code of Necropsy Procedure**
   A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

4. **Hearing Conservation Programs for Wisconsin Industries**
   Some recommended standards and principles for providing a hearing conservation program in industry.

5. **Occupational Health, A Guide for Medical and Nursing Personnel**
   General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.

6. **Find Your Future in the Health Field**
   A career guide (the health careers brochure).

7. **Guide to Immunization Planning**
   An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

8. **A Guide for Physicians, Hospitals and News Media**
   A discussion of news relationships between physicians, hospitals, newspapers and radio and television stations. It includes information concerning patients, physicians and county medical society news, health educational efforts and advice on the use of the title "Doctor."

9. **Inspection of Medical Records**
   An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

10. **School Health Examinations**
    A guide for physicians and school authorities in establishing a program of school health examinations.

11. **School Vision Screening Program**
    An outline to facilitate the development of a program to detect significant visual defects among school children.

12. **First Aid Chart**

13. **Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959**
    Relating to fee splitting between physicians and others.

14. **The Doctor's Role in Adoptions**
    A reprint of three Wisconsin Medical Journal articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

Leaders in Voluntary Health Insurance Exchange Views on Extension, Expansion

WISCONSIN PHYSICIANS SERVICE SPONSORS FIRST CONFERENCE

FREE AND unsuppressed remarks by distinguished guest speakers to an equally distinguished audience marked the success of the Conference on the Extension of Voluntary Health Insurance held November 19 and 20 at the State Medical Society headquarters in Madison. Approximately 130 visitors, guest speakers, members of the State Medical Society's Commission on Medical Care Plans, and SMS and WPS staff members attended the conference which was sponsored by Wisconsin Physicians Service.

Purpose of the conference, the first of its kind, was to bring together all of the forces interested in expanding the breadth and scope of voluntary health insurance. This included but was not limited to commercial insurance carriers (life, casualty, and health), Blue Cross and Blue Shield plans, health insurance producers, organizations whose purposes include the preservation of the private enterprise system, the Wisconsin Insurance Department, and other state agencies and officials having an interest in the subject, representatives of management and labor organizations, the Wisconsin Hospital Association, and other organizations representing or related to segments of medical care. Both the extension of benefits and how expanded benefits can be made available to more people was considered.

Participation was by invitation and pre-registration, although there were no fees. The conference convened at noon on Tuesday, November 19. A dinner of the conferees was held that evening, at which Dr. Norman A. Welch, president-elect of the American Medical Association, spoke. The conference continued through noon luncheon on Wednesday, November 20.

The conference planners were fortunate in obtaining outstanding speakers to explore, to the greatest practical extent, research and experiments into added fields of health care. There were discussions and proposals relating to health insurance benefits for the chronically physically ill, and those in need of short-term treatment of mental ailments Speakers included some of the best students of health care needs and some of the best known leaders in the health insurance field.

The conference program follows:

Tuesday afternoon—Moderator, E. M. Dessloch, M.D., chairman, Commission on Medical Care Plans, State Medical Society of Wisconsin; Welcome, W. J. Egan, M.D., president, State Medical Society of Wisconsin; Socialized Medicine, Charles A. Manson, insurance commissioner, State of Wisconsin; New Concepts in Health Insurance, Richard M. Heins, Ph.D., professor, Commerce Department, University of Wisconsin; Wisconsin's Unfilled Health Insurance Needs, John W. Joanis, executive vice-president, Hardware Mutuals—Sentry Life; and The Effects of New Benefits on the Cost of Medical Care, Walter M. Foody, Jr., vice-president, Continental Casualty Company.

Tuesday evening—Toastmaster, E. J. Nordby, M.D., councilor, State Medical Society of Wiscon-

A conference session in the Presidents' Room of the new wing of the State Medical Society building

Dr. E. M. Dessloch and Mr. John Joanis

sin; and How More Effective Medical Care Can Extend Health Insurance Benefits, Norman A. Welch, M.D., president-elect, American Medical Association.

Wednesday morning—Moderator, P. B. Mason, M.D., member, Commission on Medical Care Plans, State Medical Society of Wisconsin; Consumers' Views on Health Insurance, Frederick N. MacMillin, executive director, Wisconsin Retirement Fund; The Special Service Concept, Carl A. Tiffany, president, Carl A. Tiffany and Company; Protecting the Problem Risk, Edwin J. Faulkner, president, Woodmen Life and Accident Company; and Conference Summary, Herman L. Toser, insurance director, State Medical Society of Wisconsin.

Excerpts from Mr. Toser's summary highlight the major points emphasized at the conference.

"As we reflect upon the many ideas advanced by the guest speakers at this conference, it is not surprising that we should find some contrary and even diametrically opposed views on what is most needed to promote the cause of voluntary health insurance.

"Thank God that we live and labor in a country in which freedom of thought and speech is among the finest heritages of its citizens.

"Whether we happen to agree or disagree with the thoughts of a particular speaker on how the problems of voluntary health insurance should be solved is far less important than to freely admit that there is still much to be done.

"We are reminded once again that comparatively minor differences of opinion on precisely what should be done is far less significant than the recognition that there is even less real difference in what we consider to be our major purposes and objectives.

"As moderator of the first session of the Conference, Dr. E. M. Dessloch welcomed his audience with the reminder, 'It's a beautiful day in Madison . . . because you're here!'

"What Doctor Dessloch did not tell you attests to his modesty, for it was his foresight and that of C. H. Crownhart, secretary of the State Medical Society, who conceived the idea of this conference.

"In the welcoming remarks of Dr. W. J. Egan he urged representatives of the health insurance industry to work ever more closely with physicians who 'want, need and count on their help' in finding the solutions to problems of medical economics.

"Doctor Egan pointed specifically to the amount of physicians' time which is spent in matters relating to insurance and asked that consideration be given to the ways in which unproductive hours can be reduced in the over-all interests of providing improved medical care.

"Honorable Charles Manson discussed socialized medicine and said that he was happy to see accident and health insurance getting the increased industry attention it deserves.

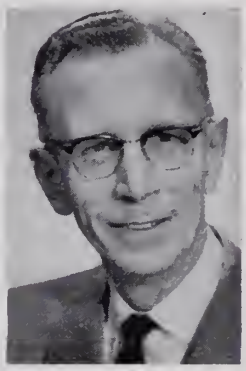
"He was understandably happy about the recognition on the part of insurance people that much remains to be done. He was understandably unhappy about the fact that complaints from policyholders are more voluminous as to sickness care benefits than as to all other forms of insurance.

"Pointing out that insurance covering all forms of health expense is apparently what the public wants, the Commissioner observed that 'It's easier to find the problems than to work out the solutions.' Mr. Manson cautioned that solutions to problems should be sought only after they have been carefully defined.

"Divided into several but related parts, Professor Heins' presentation set the tone of the conference. After pointing out statistically and otherwise the creditable job which has already been done, he pulled out the rug and uncovered the unfinished business.

"Declaring first that physicians and insurance folks have much in common, he inquired 'What seems to be the problem?' In the humble opinion of

Mr. C. H. Crownhart



Mr. H. L. Toser

this reporter, he did a commendable job of answering his own question.

"Professor Heins' paper, like that of all other speakers, deserves careful review. In it he particularizes the confusion and conflicts, which in his opinion, must be resolved if voluntary health insurance is to be extended as it deserves to be.

"In his mention of sharp claims practices and public distrust, we were comforted in the knowledge that 'The system that causes these problems can also correct them.'

"There can scarcely be any disagreement with the conclusion that the biggest problem of the health insurance industry is 'To meet the health care needs of everyone' . . . or at least as close to 'everyone' as it's possible, as a practical matter, to get.

"Professor Heins believes that among the industry's unsolved problems are the providing of insurance benefits on behalf of the chronically or continuously ill, but in this same connection noted that there must be not only a demand and a need for such benefits but the financial willingness and ability to pay for them.

Dr. L. O. Simenstad, Dr. A. A. Quisling, Dr. R. E. Galasinski, and Dr. E. L. Bernhart

Dr. W. J. Egan and Dr. James C. Fax

"What to do about the emotionally disturbed, nursing home care, substandard or uninsurable risks, paid-up policies, broader contract definitions, and a variety of other matters illustrated with unmistakable clarity the challenges still to be met. Without team work, these challenges will remain unanswered.

"Professor Heins asked, 'Is there still time to do these things before they are resolved at the national (and, I presume, government) level?' Reminded of Commissioner Manson's earlier remarks, I am prompted to add, 'It's a lot easier to find the problem than to discover the answer' . . . but it must be found if the free enterprise system in health care and health care insurance is to survive.

"The establishment of minimum coverage, greater standardization and simplification of forms, joint research efforts, a cooperative public relations program, effective controls of benefit utilization, the observance always of high standards of ethics, and the development of greater interest on the part of policyholders in the amounts of their sickness care bills were listed by Professor Heins as worthy of exploration.

The major problem in old-age coverage revolves around the accumulation of resources for terminal illness.

"As though we didn't already have enough problems, John W. Joanis plowed up some old ones and planted a few new ones. Referring to another meeting held earlier in the day, Mr. Joanis' discussion began with the expressed hope that revival and revision of the so-called 'Wisconsin Plan' would pave the way for remedying other defects in this state's health insurance picture.

"Mr. Joanis' good judgment was reflected in his evaluation of the audience, which he described as being 'of high caliber.'

"In suggesting that we take a good look at ourselves, Mr. Joanis first traced the history of Kerr–Mills legislation and the 'State 65 Plan' approach to insurance for the elderly and then suggested with respect to the latter, 'Don't jump too rapidly.' He also expressed the view that these activities did serve a purpose in stimulating private insurance carriers to do a better job.

"Having commented previously that the insurance buyer cannot realistically expect to get something for nothing, a plea was made for continued adherence to sound insurance principles, including those relating to competition and the need for making health insurance contracts pay their own way.

"In illustrating his conviction that we should be daring enough to 'explore new concepts,' Mr. Joanis suggested we think about what he called 'wage replacement' benefits . . . with scheduled cash payments during illness to the policyholder . . . who in turn would pay the vendors of health care services directly.

"He concluded that perhaps government pressure on the health insurance industry wasn't all bad. . . since it appeared to have used a needle long and sharp enough to get some action!

"The next speaker . . . Walter M. Foody, Jr. . . . has a flair for research and the interpretation of statistics. His talk began with the observation that 'The only true research is in the market place.'

"In Mr. Foody's opinion, the public generally has accepted rising health insurance costs because of the dramatic prolongation of life, the acknowledged improvement in medical care, and the documentation of pertinent facts in the press. At the same time, he remarked that 'projections stagger the imagination and seem unrealistic.' The latter certainly suggests that greater steps be taken to convince the public that the health insurance industry does not in fact 'encourage' any excesses in the utilization of contract benefits.

"Mr. Foody discussed in some detail what might be expected of home care programs in terms of reducing total present health care costs. His conclusion was that benefits have to be expended for the intended purpose and that home care program benefits will supplement but not supplant hospital benefits.

"On the optimistic side our after-dinner speaker, Doctor Welch, said that despite its imperfections, our present health system is still the best of all countries . . . and that about four and a half million Americans are living today who would not have been alive had the mortality rate of 25 years ago continued.

"Pointing out that the number of persons covered by health insurance policies had tripled in the past 10 years, Doctor Welch observed that 'If you're successful, they investigate you . . . God knows what they'll do if you're unsuccessful.'

"It was evident from the doctor's sound advice that the time for complacency in the medical profession and the health insurance industry has not yet arrived.

"Mr. Frederick N. MacMillin, who opened the second session of the conference, said 'As in most areas we've discovered that you can't get something for nothing.' He has discovered, too, that deductibles are not popular with employees and that catastrophic or major medical coverage is deserving of far more consideration than protection against small losses, where administrative costs are proportionately high.

"The need to control benefit utilization, and thereby health insurance costs, was stressed. His specific recommendations on accomplishing this are deserving of our thoughtful consideration. His remarks relating to nursing home and home care coverage may well provide the answer to some of our problems in the area of hospital benefit utilization.

"Mr. MacMillin feels that much remains to be done in providing proper benefits on behalf of senior citizens . . . even to the point where younger people subsidize their elders in meeting the cost of health care. He advocated that the whole problem of the mentally ill and the financial burdens which may be imposed upon them as a consequence of this ailment be the subject of serious deliberation by insurance buyers.

righted, that copies of it are available on request, and that with or without deductibles and/or coinsurance, it offers promise of substantial public appeal.

"Anticipating the questions of his audience, Mr. Tiffany spoke of the problems which it was expected would arise and of the manner in which they have been met.

"Complimenting the Medical Society in meeting the need for improved communications within the industry, Mr. Edwin J. Faulkner expressed the hope that similar conferences will be held in the future. We agree with him.

Mr. Charles Manson, Mr. W. M. Foody, Jr. and Mr. F. N. MacMillin

Establishment of home-care programs as an effective alternative to long-term hospitalization of the chronically ill can produce tremendous savings.

"Mr. Carl A. Tiffany, a consulting actuary for insurance companies, discussed the special service concept. This subject related to the so-called 'no-fee-schedule' philosophy of Wisconsin Physicians Service. Your reporter, while claiming no credit for either its origin or its success, is prejudiced in his views on its tremendous potentiality.

"Referring to the Special Service concept as the largest single contribution made by Wisconsin Physicians Service to the Blue Shield 'full pay' philosophy, Mr. Tiffany traced its history and outlined what he felt had been accomplished through its introduction.

"Reviewing the pertinent provisions of the Special Service Contract, Mr. Tiffany discussed the implementation of the policy and the manner in which controls are instituted. It is his contention, as it is that of his client, that the omission of stated fees in the contract is not inflationary.

"It should be noted that the Special Service Contract of Wisconsin Physicians Service is not copy-

"Mr. Faulkner said our job is to make better health care insurance available to more people . . . but to make it available to all segments of our society is an unrealistic and impracticable goal for reasons he outlined.

"With respect to problem risks, Mr. Faulkner gave his reasons for believing that insurers, too, must recognize the areas in which private insurance does not, should not, and cannot effectively perform its expected functions.

"With special reference to the insurance problems of the aged, Mr. Faulkner reminded us that 60 per cent of those 65 years of age or older are already insured. He recommended the specific ways in which he felt that this activity might be accelerated, especially so through the employment of mass enrollment techniques at minimal expense.

"The pros and cons of 'Plan 65' programs were reviewed, but Mr. Faulkner felt it is too early to pass intelligent judgment on the extent to which they serve their purpose.

Mr. E. J. Faulkner

Prof. R. M. Heins

"It is evident from all that has been said that increased activity in the areas of consumer research and public education are among our greatest and most pressing needs. We must have the foresight and courage, on the basis of fact finding, to disagree at times with what some segment of the public *thinks it wants* as contrasted with *what is in their best interests* in the way of health insurance benefits.

"There are still those who believe that health insurance contracts should provide so-called 'first dollar' sickness care coverage, including even reimbursement for the cost of home and diagnostic examinations whenever and wherever taken.

"While it may be difficult to convince those holding this belief that there's anything economically wrong about that kind of prepaid financial arrangement, it appears that the industry has up to now at least not made an adequate, concerted effort to do so.

"On the other side of the coin, it must be acknowledged that although limitations in benefits obviously have a direct bearing on the cost of providing insurance, the total cost of sickness care, even where insurance is present, is the combined sum of insurance premiums plus those out-of-pocket costs not covered by insurance.

"With this in mind, the responsibility of those of us who are associated in one way or another with voluntary health insurance is not only in the fields of insurance but also in the fields of health care facilities and the *total* cost of health care.

"We find too many reasons for rationalizing the relationship between the increased cost of health insurance benefits, the seemingly never ending inflationary aspects of our economy, and the great advances made in providing medical care.

"We find too few reasons for finding fault with ourselves . . . and for aggressively tackling those problems which can be settled 'in our own house,' so to speak.

"Among those problems, in addition to the need for research and education generally, are the specific communication of rating information to policyholders, the wider availability of conversion privileges, a greater willingness to experiment with new or broadened benefits, and the danger that we are overlooking the importance of individual policyholders as we seek the financial rewards of mass production, automation, and other forms of mechanization.

"The reference to rating information requires some explanation. I'm not talking about the actuarial elements or the technical details of rating formulae. I am talking about the simple arithmetic of health insurance premiums . . . and the removal of the alleged mystery about what causes rate increases.

"And, as long as we're on the subject of rate increases, our customers need to know to what practicable extent their utilization of available benefits makes them partners in the business of setting premium charges.

"We need to remind our public constantly that the modern concept of adequate sickness care includes an ever-growing list of facilities and services, and that there is in fact little justification for comparing their dollar costs with those of the past without also comparing the quality and quantity of the care provided.

Dr. Norman A. Welch

Mr. Carl A. Tiffany

"Should we fail to meet the challenge of better communication in this and related areas, we can realistically expect in the years immediately ahead that those already bitten by the bug of compulsory health insurance may increase dangerously in number.

"Common sense tells us that the plans of insuring organizations for the extension of voluntary health insurance must contemplate the development of a continuously better public image. On the basis of past experience, it is not difficult to find a starting point.

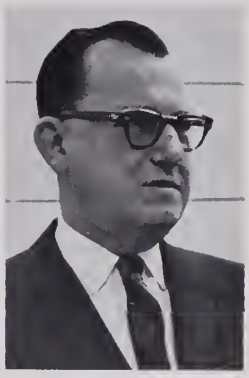
Increased activity in the areas of consumer research and public education are among our greatest and most pressing needs.

"The greatest single criticism directed at the providers of health insurance by policyholders is that the benefits available when a claim occurs is not what they were led to expect when the contracts were purchased.

"You know, I know, and every insurance supervisory body in the country knows that many buyers of insurance have unbelievably short memories. We also all know that such criticisms are not aimed solely at health insurance carriers. But we know, too, that neither of these defenses is completely valid. There is something we can do about the problem.

"As to both individual and group contracts, advertising materials, application forms, enrollment booklets, and contract documents should more clearly specify benefit or coverage intent. As to application forms in particular, any benefits *offered but not accepted* should be clearly indicated by the applicant as 'not wanted.'

Dr. E. J. Nordby



Dr. P. B. Mason

The importance of the present Ways and Means hearing on the King-Anderson bill can be stressed by the fact that the country is only two votes away from socialized medicine, as indicated by the present voting lineup in the committee.

"This technique has long been employed to advantage as to other forms of insurance. And, borrowing from the experience of new car automobile dealers in recent years, let's price our health insurance package in such a way that there's no doubt about which of the most vital parts and which of accessories or 'extras' are included in the purchase price.

"In insurance selling this practice is known variously as 'top-down' or 'complete package' merchandising. It simply means that the policyholder places himself on record concerning the available coverages he elects not to purchase. The advantages of such a system to all the functions within an insurance organization should be self-evident.

"There are almost countless numbers of ways in which the already great institution of voluntary health insurance can further advance the cause for which it has fought so courageously. The trumpets and bugles referred to by Professor Heins have been sounded. The call to battle and eventual complete victory is clear. All it takes to win . . . ingenuity, resourcefulness, and determination . . . are qualities we have in great abundance.

"The question before the house is this: When we meet again, how much closer will we be to solving our problems than we are today? The answer is up to us!"

Plans have already begun for another conference next year.

The entire transcript of the conference will be published in booklet form and distributed to all those who participated. Additional copies also will be available for anyone else who may be interested. Requests should be addressed to: Wisconsin Physicians Service, Box 1109, Madison, Wis. 53701.

PARTICIPANTS AT THE CONFERENCE

John Allen, M. D., Medical Consultant, State of Wisconsin, Division of Public Assistance, Madison, Wis.; Robin N. Allin, M. D., Chairman, Committee on Health Economics of American Life (HEAL), State Medical Society of Wisconsin, Madison, Wis.; Mr. Warren Anderson, Geyer–Morey–Ballard, Inc., Racine, Wis.; Robert S. Baldwin, M. D., Consulting Editor, *Wisconsin Medical Journal*, Marshfield, Wis.; I. E. Bartlett, M. D., Chairman, Medical Economics Committee, Illinois State Medical Society, Wheaton, Ill.; Thomas J. Bergen, Esq., Wisconsin Association of Nursing Homes, Inc., Milwaukee, Wis.

E. L. Bernhart, M. D., A. M. A. Delegate, Milwaukee, Wis., Mr. Harold E. Bliss, Manager, Group Division, Employers Mutuals, Wausau, Wis.; Mr. Luther Boie, Mayo Clinic, Rochester, Minn.; Mr. C. Clark Bryan, American Life Convention, Chicago, Ill.; Mr. John C. Burridge, Associate Editor, *National Underwriter*, Chicago, Ill.; W. T. Clark, M. D., State Board of Health, Janesville, Wis.; Mr. Robert Collien, Vice-president, First National Casualty Co., Fond du Lac, Wis.; Miss Alice M. Chellberg, Assistant Secretary, American Mutual Insurance Alliance, Chicago, Ill.; Mr. J. M. Cooper, Insurance Manager, American Motors Corporation, Detroit, Mich.

Mr. C. H. Crownhart, Secretary, State Medical Society of Wisconsin, Madison, Wis.; William P. Curran, M. D., President-elect, State Medical Society of Wisconsin, Antigo, Wis.; Mr. Floyd R. Detert, Clinic Manager, Marshfield Clinic, Marshfield, Wis.; Mr. Donald Eagles, Executive Vice-president, North Dakota Physicians Service, Fargo, N. D.; W. J. Egan, M. D., President, State Medical Society of Wisconsin, Milwaukee, Wis.; Norbert N. Enzer, M. D., Milwaukee County Medical Society, Milwaukee, Wis.; Mr. Edwin J. Faulkner, President, Woodmen Life and Accident Co., Lincoln, Neb.; Mr. Robert W. Fleming, Mayo Clinic, Rochester, Minn.; Mr. W. M. Foody, Jr., Vice-president, Continental Casualty Co., Chicago, Ill.; James C. Fox, M. D., Chairman, Council of State Medical Society of Wisconsin, La Crosse, Wis.; Mr. Harold Frey, Representative, Wisconsin Council of Hospital and Homes for the Aged, Milwaukee, Wis.

R. E. Galasinski, M. D., A.M.A. Delegate, Milwaukee, Wis.; Mr. Melvin A. Glasser, Director, Social Security Department, International Union, UAW, Detroit, Mich.; Miss Gertrude M. Gloecker, Executive Secretary, Wisconsin

Conference of Catholic Hospitals, Milwaukee, Wis.; Mr. Ralph E. Gintz, Director, Workmen's Compensation Division, Industrial Commission, Madison, Wis.; Mr. Lawrence A. Grovlik, Wisconsin Insurance Consultants, Inc., Racine, Wis.; Mr. Harold C. Guntner, President, Wisconsin Hospital Association, Menomonie, Wis.; Mr. Philip S. Habermann, Executive Director, State Bar, Madison, Wis.; Mr. William Henning, Representative, Rural Mutual Insurance Co., Madison, Wis.

Richard M. Heins, Ph.D., Professor, Commerce Department, University of Wisconsin, Madison, Wis.; Nels A. Hill, M. D., Past President, State Medical Society of Wisconsin, Madison, Wis.; Mr. F. J. Holton, President, Classified Risk Insurance Corporation, Milwaukee, Wis.; H. O. Hoppe, D.D.S., Wisconsin Dental Service Corporation, Milwaukee, Wis.; Mrs. May Hornack, R. N., Wisconsin Nurses Association, Poynette, Wis.; Mr. Leland W. Hulett, Milton College, Milton, Wis.; Mr. John Joanis, Vice-president, Sentry Life Insurance, Stevens Point, Wis.; Mr. Robert M. Jones, President-elect, Wisconsin Hospital Association, Waukesha, Wis.; Mr. M. W. Kiley, President, Wisconsin Accident and Health Underwriters, Madison, Wis.; Mr. R. G. Knutson, Member, Industrial Commission, Madison, Wis.

Mr. V. S. Ladegaard, General Personnel Supervisor, Wisconsin Telephone Co., Milwaukee, Wis.; Patricia Lanier, M. D., Governor's Commission on Aging, Kewaunee, Wis.; Mr. Lyle A. Limond, Executive Secretary, North Dakota State Medical Association, Bismarck, N. D.; Mr. Jack Lowe, Sentry Life Insurance, Stevens Point, Wis.; Mr. Fred Luick, American Family Life Insurance, Madison, Wis.; Mr. A. J. Luthmers, Medical Society of Milwaukee County, Milwaukee, Wis.; Mr. D. C. Lynn, President, Wisconsin Mutual Insurance Co., Madison, Wis.; Mr. Robert H. McGee, Executive Director, Wisconsin Retirement Fund, Madison, Wis.; Mr. F. N. MacMillin, Executive Director, Wisconsin Retirement Fund, Madison, Wis.; Mr. Charles Manson, Insurance Commissioner, Wisconsin Insurance Department, Madison, Wis.; Mr. D. F. McIntyre, Thresherman's Mutual Insurance Co., Fond du Lac, Wis.

Mr. James F. McMichael, Governor's Commission on Aging, Madison, Wis.; Mr. R. B. Murphy, Murphy, Desmond Stolper, Madison, Wis.; Mr. Robert Nelson, Rural Mutual Insurance Co., Madison, Wis.; Milton E. Nugent, M. D., North Dakota State Medical Association, Bismarck, N. D.; Mr. Louis Olson, American Family Life Insurance Co., Madison, Wis.; Mr. Delbert Paulman, Wisconsin Insurance Department, Madison, Wis.; Dr. George Palmer, Wisconsin Council of Hospital and Homes for the Aged, Milwaukee, Wis.; George H. Peterson, M. D., Fisher Body Division, General Motors Corp., Janesville, Wis.; A. A. Quisling, M. D., Delegate, American Medical Association, Madison, Wis.; Mr. John E. Roberts, Executive Secretary, Wisconsin Interscholastic Athletic Assoc., Stevens Point, Wis.; Mr. J. R. Ruddy, Representative, Continental Casualty Co., Chicago, Ill.

Mr. Richard Smiley, Wisconsin Insurance Department, Madison, Wis.; Mr. Edward F. Schulkers, Manager, Milwaukee Group Office, John Hancock Mutual Life Insurance Co., Milwaukee, Wis.; J. S. Semrau, D. D. S., Wisconsin State Dental Society, Milwaukee, Wis.; Mr. C. D. Smith, Washington National Insurance Co., Evanston, Ill.; Mr. Stanford Smith, Wisconsin Telephone Co., Milwaukee, Wis.; Mr. Arthur W. Schumacher, Legal Counsel, Associated Hospital Service, Inc., Milwaukee, Wis.; Mr. C. B. Stumpf, Illinois Mutual Insurance Co., Madison, Wis.; Mr. Donald L. Taylor, Executive Director, Iowa State Medical Society, Des Moines, Ia.; Mr. James Tenney, Association of Life Insurance Medical Directors, New York, N. Y.

Miss Shirley Thude, Wisconsin Manufacturers Association, Milwaukee, Wis.; Mr. Carl A. Tiffany, President, Carl A. Tiffany and Co., Chicago, Ill.; Mr. Herman L. Toser, Insurance Director, State Medical Society of Wisconsin, Madison, Wis.; Mr. Daniel Vandehey, Langlade Memorial Hospital, Antigo, Wis.; C. O. Vingom, M. D., State Medical Society of Wisconsin, Madison, Wis.; Mr. Warren R. Von Ehren, Executive Director, Wiseonsin Hospital Association, Madison, Wis.; Norman A. Welch, M. D., A.M.A. President-elect, Boston, Mass.; Alice A. Weldy, R. N., Executive Secretary, Wisconsin Nurses Association, Milwaukee, Wis.

F. L. Weston, M. D., Treasurer, State Medical Society of Wisconsin, Madison, Wis.; Mr. W. A. Weisleder, District Manager, Liberty Mutual Insurance Co., Milwaukee, Wis.; Mr. John B. White, Donald E. Gill & Co., Madison, Wis.; Mr. Kenneth Willis, Time Insurance Co., Milwaukee, Wis.; George G. Young, M. D., Iowa State Medical Society, Des Moines, Ia.; Mr. John L. Zimbeck, State of Wisconsin Group Insurance Board, Madison, Wis.

PARTICIPATING MEMBERS OF THE COMMISSION ON MEDICAL CARE PLANS, STATE MEDICAL SOCIETY OF WISCONSIN

E. M. Dessloch, M. D., Chairman, Prairie du Chien, Wis.; G. W. Carlson, M. D., Appleton; W. T. Casper, M. D., Milwaukee; M. D. Davis, M. D., Milton,; K. H. Doege, M. D., Marshfield; Milton Finn, M. D., Superior; D. N. Goldstein, M. D., Kenosha; A. W. Hilker, M. D., Eau Claire,; J. H. Houghton, M. D., Wisconsin Dells; Donald A. Jeffries, M. D., Shawano; Robert Krohn, M. D., Black River Falls; P. B. Mason, M. D., Sheboygan; A. J. McCarey, M. D., Green Bay; E. J. Nordby, M. D., Madison; C. G. Reznichek, M. D., Madison; L. O. Simenstad, M. D., Osceola; John T. Sprague, M. D., Madison; F. H. Wolf, M. D., La Crosse.

WISCONSIN VOICE AT A.M.A. MEETING

Parent–Teacher–MD Threesome

MD CALLS FOR TEAMWORK TO PREVENT SPORTS INJURIES

When it comes to preventing high school athletic injuries, the responsibility lies with "a team made up of parents, coaches, team physicians and school administrators," and members of this team must understand and believe in one another, Dr. James C. H. Russell of Fort Atkinson, Wis., said yesterday.

Dr. Russell appeared before the Fifth National Conference on Medical Aspects of Sports.

Parents can interfere with a prevention program in two ways, he said.

"One is the insistence that their son play when he is not ready. They are willing to sign releases for responsibility for injury when they are not qualified to judge," he said. The other is their failure to understand that training and conditioning are essential to the prevention of injury. "They know when their sons are not following the rules and they frequently sanction it or overlook it," he said.

The key role in the injury-prevention team is the head coach, Dr. Russell emphasized. "If a school cannot provide a man who is properly trained to supervise a sport, that activity should not be included in its athletic program."

This is particularly true in wrestling, the fastest growing interscholastic sport, he said.

"Many inexperienced coaches are trying to handle this sport leading to cauliflower ears and other preventable injuries," he reported.

Dr. Russell advocates a team physician for every contact sport "sitting on the bench or very close to it. He should travel with the team if at all possible: taking care of one team is a complex job, without attempting to care for both teams," he said. He also cited the use of hand-me-down equipment by junior varsity and freshman football teams as contributing to injury.

Reprinted from *The Daily Bulletin* of the American Medical Association, published at Portland, Ore., Dec. 2, 1963, during A.M.A. Clinical Meeting.

GENERAL PRACTITIONER or internist to take over a thriving established practice in new northwest side of Milwaukee. Plan to specialize in one to two years. Office large enough for two physicians with x-ray and laboratory facilities. Willing to turn over entire practice. Equipment can be purchased at cost. Contact Dept. 65 in care of the Journal. m9tfn

ALLERGIST WANTED to share offices with dermatologist. Located in thriving area, south central Wisconsin. Unusual opportunity. Applicant must be board certified or qualified and intending to become certified. Reply, with details of personal and professional qualities and qualifications, to Dept. 5 in care of the Journal. m8tfn

FOR RENT: OFFICE SPACE, 1200 sq. ft., for medical offices in modern, air-conditioned building at 16 East Gorham Street, Madison. Available for immediate occupancy. Will accommodate one or two physicians, preferably internists. Off-street parking. Contact Robin Allin, M.D., 1313 Fish Hatchery Road, Madison, Wis., phone ALpine 6–5521; or residence CEdar 3–2082. m8tfn

PHYSICIANS, with or without pediatric training, needed in maternal and child health program at salaries ranging from $9,960.00 to $13,200.00. Five-day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, Milwaukee Health Department, Municipal Building, Milwaukee 2, Wis. g8tfn

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INDEX

A Monthly Journal of Medicine and Surgery

with organizational coverage of the medicolegal, socio-economic, ancillary, and public relations aspects in the practice of medicine

VOLUME 62

JANUARY 1963–DECEMBER 1963

INDEX VOL. 62, 1963

The symbols used to indicate which department the matter indexed appears are as follows: "E", Editorial; "PP", President's Page; "ab", abstracts; the asterisk (*) indicates an original article; "CPC" indicates clinicopathologic conference; "CT", comments on treatment; "SBH", State Board of Health; "MF", Medical Forum; these symbols precede page number. Whenever a page number such as "2–37" appears, the first number refers to the month of issue, the second number to the page. Whenever a page number such as "385" appears, the number refers to the scientific section which is numbered consecutively through the 12 issues of the volume; the following table indicates the page numbers of the scientific section for each month:

MONTH	PAGES	MONTH	PAGES	MONTH	PAGES
January	1–108	May	207–240	September	365–394
February	109–140	June	241–292	October	395–424
March	141–182	July	293–328	November	425–494
April	183–206	August	329–364	December	495–566

AUTHORS OF SCIENTIFIC ARTICLES

Page

Aldrich, C. Knight, Chicago, Ill. 114
Appleby, Keith B., Milwaukee 149
Atamdede, Yasar, Milwaukee 337

Baronofsky, Ivan D., San Diego, Calif. 495
Bartholomew, R. D., Wausau 349
Brown, Henry, Madison 400
Bump, Warner S., Rhinelander 125

Calvert, Deane N., Milwaukee 324, 440
Close, A. Stephen, Milwaukee 501

Dale, Allan J. D., Rochester, Minn. 302
Dick, H. J., Sheboygan 195

Ellison, Edwin H., Milwaukee 501
Evans, Alfred S., Madison 211, 329
Evrard, John R., Milwaukee 185, 500

Falk, V. S., Edgerton 431
Frackelton, William H., Milwaukee 505
Franklin, Donald A., Milwaukee 365

Gallagher, W. B., La Crosse 334
Garner, Lawrence L., Milwaukee 371
Geraci, Joseph E., Rochester, Minn. 302
Gingrass, Ruedi P., Milwaukee 501
Glassy, Frank J., Sacramento, Calif. 316
Griese, George G., Marshfield 145
Gutglass, Milton F., Milwaukee 337

Hardman, Harold F., Milwaukee 268, 417
Hinke, Marvin L., Madison 119
Hofmeister, Frederick J., Milwaukee 506

Jaeck, James L., Sheboygan 152

Kalfayan, Bernard, La Crosse 129
Kascht, Robert L., Waukesha 383
Kleppe, L. W., Beloit 507
Klieger, Jack A., Milwaukee 185
Kreul, William, Racine 203

Lawton, Ben R., Marshfield 145
Liebenow, R. R., Lake Mills 347
Lipton, Aaron H., Milwaukee 433

Page

Llewellyn, M. B., Janesville 410
Lubitz, Joseph M., Milwaukee 262
Lucas, George L., Madison 405
Lum, Bert K. B., Milwaukee 353
Lynn, Thomas E., Green Bay 191

March, J. F., Algoma 257
McGoon, Dwight C., Rochester, Minn. 302
Meade, Robert C., Milwaukee 365
Meighan, Pearse, Appleton 436
Middleton, William S., Washington, D. C. 109
Morris, David L., West Salem 252

Nevin, I. Nik, Rhinelander 125, 395

Peckham, Ben M., Madison 217, 506
Piper, Philip G., Madison 207
Pisciotta, Anthony V., Milwaukee 230
Pratt, George F., Rhinelander 498
Pribek, Robert A., La Crosse 141
Price, Daniel J., Milwaukee 504

Richards, W. G., Beaver Dam 425

Salibi, Bahij S., Marshfield 375
Schiek, Irving E., Jr., Rhinelander 125
Seifert, Kenneth A., Milwaukee 259
Simon, Thomas R., Milwaukee 223
Stoll, William M., Green Bay 416
Sullivan, John T., Jr., Milwaukee 149

Teasley, Jack L., Milwaukee 505
Tegtmeyer, G. F., Jr., Madison 429
Teresi, Joseph L., Milwaukee 342

Van Duser, A. L., Madison 221
Van Wormer, Dale E., Madison 183
Vermund, Halvor, Madison 119

Wagner, Marvin, Milwaukee 342
Way, James L., Milwaukee 157, 378
Way, R. W., Beaver Dam 425
Wirka, Herman W., Madison 405

Yard, Albert C., Milwaukee 135, 202

AUTHORS OF NONSCIENTIFIC ARTICLES

Page

Annis, Edward R. (MD), Miami, Fla. 294

Brown, W. O., Madison 143

Chambers, Catherine (RN), Madison 190

Davis, Milton D. (MD), Milton 359

Page

Egan, W. J. (MD), Milwaukee 241, 326, 356, 390, 420, 442, 513
Etter, Kathryn (RN) Monroe 403
Evans, Alfred S. (MD), Madison 329

Goldstein D. N. (MD) Kenosha 98, 100, 139, 160, 161, 205, 234, 235, 271, 272, 327, 358, 360, 393, 394, 422, 423, 515, 516

	Page
Heise, Herman A. (MD), Milwaukee	243
Hill, N. A. (MD), Madison	97, 137, 159, 204
Hirschboeck, John S. (MD), Milwaukee	293
McIllece, Patricia E. (MD), Madison	512
Murphy, Rose Ann, Lansing, Ia.	416
Nashold, R. D. (MS), Madison	249
Preizler, Josef (MD), Madison	403
Rowley, Ione M. (RN), Madison	511
Samp, R. J. (MD), Madison	229
Tschudy, Martha (RN), Monroe	403
Wadsack, Horst (MS), Madison	249
Wardlaw, James L. (MD), Madison	190
Zeit, Walter (PhD), Milwaukee	295

SCIENTIFIC ARTICLES/ABSTRACTS/INFORMATION

	Page
ABRUPTIO PLACENTA, Catastrophy of; obstetrical brief (Hofmeister)	506
ACUTE PANCREATITIS, Transient and persistent duodenal obstruction secondary to (Nevin)	*395
ADENOCARCINOMA (Kleppe)	CPC–507
ADENOMA of rectosigmoid (Kalfayan)	CPC–129
ADOLESCENCE, Expectations—great and otherwise (Aldrich)	*114
AGRANULOCYTOSIS, Some comments on pathogenesis of (Pisciotta)	CT–230
ALKYLPHOSPHATE CHOLINESTERASE INHIBITORS, Treatment of poisoning due to (Way)	CT–157
AMNIOTIC FLUID EMBOLIZATION (Meighan)	CPC–136
ANGIOTENSIN (Yard)	CT–135
ANTITHYROID DRUGS (Calvert)	CT–440
APPENDICITIS, Acute (Jaeck)	CPC–152
—— and pregnancy	ab–210
ARTIFICIAL HEART VALVE for humans developed at University of Wisconsin	12–47
BICILLIN prophylaxis program (McIllece)	512
BLOOD preservation a reality, Long-term	ab–399
—— transfusions, Abuse of one-pint	ab–352
BOWEL RESECTION, Emphysema of face following (Falk)	*431
BRAIN STEM vascular accident following neck manipulation (Pribek)	*141
BREAST, Co-existent cystosarcoma phyllodes and scirrhous adenocarcinoma of (Richards and Way)	*425
CANCER sites, Trends in three (Van Duser)	*221
CARDIAC COUNTERSHOCK, Termination of resistant tachycardia by (Morris)	*252
CARDIAC OPERATIONS, Bacterial endocarditis and endarteritis following (Geraci, Dale & McGoon)	*302
CAROTID sinus pressure, Death following	ab–333
CARPAL NAVICULAR FRACTURES when diagnosis has been delayed, Treatment of undisplaced (Pratt)	*498
CHEMOTHERAPY of herpes simplex virus and vaccinia virus (Hardman)	CT–417
CHIROPRACTIC, Brain stem vascular accident following neck manipulation (Pribek)	*141
CHLOROTHIAZIDE, Hyperglycemia and (March)	*257
CHLORPROPAMIDE in treatment of multiple sclerosis (Tegtmeyer)	*429
CIRRHOSIS, Primary biliary (Lubitz)	CPC–262
CLINICOPATHOLOGIC CONFERENCES, Acute appendicitis (Jaeck)	152
—— Adenoma of rectosigmoid (Kalfayan)	129
—— Amniotic fluid embolization (Meighan)	436
—— Astrocytoma of the pons (Bartholomew)	349
—— Chronic cor pulmonale (Llewellyn)	410
—— Leukemia (Dick)	195
—— Mesodermal mixed tumor, malignant (Simon)	223
—— Primary biliary cirrhosis (Lubitz)	262
—— Rickets (Kascht)	383
—— Wound abscess (Kleppe)	507
COLLAGEN DISEASES, Laboratory diagnosis of (Glassy)	*316
COMMENTS ON TREATMENT, Angiotensin (Yard)	135
—— Antithyroid drugs (Calvert)	440
—— Chemotherapy of herpes simplex virus and vaccinia virus (Hardman)	417
—— Oral hyperglycemic agents (Calvert)	321
—— Pharmacology—"a justification" (Hardman)	268
—— Pharmacology of methyldopa; an antihypertensive drug (Lum)	353
—— Some comments on the pathogenesis of agranulocytosis (Pisciotta)	230
—— Sparteine—a new oxytocic drug (Yard)	202
—— Treatment of poisoning due to alkylphosphate cholinesterase inhibitors (Way)	157
—— Treatment of poisoning due to cyanide (Way)	378
CONGENITAL ESOPHAGEAL ATRESIA with tracheoesophageal fistula, Secondary surgery of (Stoll)	*416
CONSCIOUSNESS in acute head injuries, Levels of (Salibi)	*375
COR PULMONALE, Chronic (Llewellyn)	CPC–410
CYANIDE, Treatment of poisoning due to (Way)	CT–378
CYSTOSARCOMA PHYLLODES and scirrhous adenocarcinoma of breast, Co-existent (Richards and Way)	*425
CYTOLOGY, a community service (Piper)	*207
—— demonstration slides available	270
—— in diagnosis of uterine carcinoma in a private hospital, Experience with	ab–220
—— in medical practice today, Cervical (Peckham)	*217
—— in Wisconsin, Present status of services for cervical (Evans)	*211
—— Optimum spacing of repeat follow-up Papanicolaou smears	ab–222
—— Revolution in	E–235
—— Screening for uterine cancer through physicians' offices	ab–210
—— Tampon method for mass screening to detect carcinoma of cervix uteri	ab–210
DIABETES, Diabetic nephropathy without manifest	ab–136
—— Hyperglycemia and chlorothiazide (March)	*257
—— Oral hypoglycemic agents in diabetic patients with pulmonary tuberculosis	ab–138
—— Oral hypoglycemic agents (Calvert)	CT–324
—— Statistics on diabetic patients cited	ab–394
DIAGNOSTIC ABILITY available for physicians' meetings, Units to test	256
DUODENAL OBSTRUCTION secondary to acute pancreatitis, Transient and persistent (Nevin)	*395
DUPUYTREN'S DISEASE, Present day treatment of (Frackelton and Teasley)	*505
EMPHYSEMA of face following bowel resection (Falk)	*431
ESOPHAGUS, Spontaneous rupture of (Lynn)	*191
—— Esophageal hiatus hernia (Baronofsky)	*495
FALLOPIAN TUBES, Leiomyoma of (Lipton)	*433
FARM ACCIDENTS occurring in children (Lucas and Wirka)	*405
FETAL DISTRESS in labor (Klieger and Evrard	*185
FRACTURES, Treatment of undisplaced carpal navicular, when diagnosis has been delayed (Pratt)	*498
FROSTBITE, Treatment of	ab–158
GALLBLADDER and cystic duct, Congenital absence of (Seifert)	*259

Page

—— Roentgen diagnosis of compartmental disease of (Nevin, Bump and Schiek, Jr.) *125
—— Torsion of (Sullivan and Appleby) *149
GAMMA GLOBULIN, Shortage of 201
GASTRIC SURGERY (Gallagher) *334
GLAUCOMA, Perilimbal suction-cup: new method for early diagnosis of (Garner) *371
GASTROINTESTINAL TRACT, Plasma proteins and ab–355

HEAD INJURIES, Levels of consciousness in acute (Salibi) *375
HEART in sarcoidosis: Hutchinson–Boeck granulomatosis (Middleton) *109
—— Bacterial endocarditis and endarteritis following cardiac operations (Geraci, Dale and McGoon) *302
—— Chronic cor pulmonale (Llewellyn) CPC–410
—— Termination of resistant tachycardia by cardiac countershock (Morris) *252
HERNIA; clinical, radiologic, and endoscopic study of one hundred cases; Symptomatic esophageal hiatus sliding ab–232
—— Esophageal hiatus (Baronofsky) *495
HERPES SIMPLEX VIRUS and vaccinia virus, Chemotherapy of (Hardman) CT–417
HYPERGLYCEMIA and chlorothiazide (March) *257
HYPOGLYCEMIC AGENTS, Oral (Calvert) CT–324; correction, 399

IODINE 131 in milk, Report on 242

LABOR, Fetal distress in (Klieger and Evrard) *185
LABORATORY DIAGNOSIS of collagen diseases (Glassy) *316
LEAD POISONING 12–11
LEIOMYOMA of fallopian tubes (Lipton) *433
LEUKEMIA (Dick) CPC–195
LIVER, Primary biliary cirrhosis (Lubitz) CPC–262

MAMMOGRAPHY by American Cancer Society, Policy statement on 228
MANIPULATION, Brain stem vascular accident following neck (Pribek) *141
MATERNAL MORTALITY, Trichlorethylene, Trilene, Trimar analgesia in obstetrics (Kreul) 203
MEASLE VACCINE, Attenuated 510
METHYLDOPA; an antihypertensive drug; Pharmacology of (Lum) CT–353
MULTIPLE SCLEROSIS, Chlorpropamide in treatment of (Tegtmeyer) *429

NECK manipulation, Brain stem vascular accident following (Pribek) *141
NEWBORN MALFORMATION, Vascular ring anomalies (Griese and Lawton) *145

ORGAN SCANNING, Clinical use of radioisotopes for (Meade and Franklin) *365
OTITIS MEDIA in infants, Autopsy incidence of (Van Wormer) *183
OXYTOCICS; Sparteine—new drug (Yard) CT–202
—— Employment and safeguards; obstetrical brief (Evrard) 500
OBSTETRICS, Catastrophy of abruptio placenta; obstetrical brief (Hofmeister) 506
—— Fetal distress in labor (Klieger and Evrard) *185
—— Oxytocics: employment and safeguards; obstetrical brief (Evrard) 500
—— Sparteine, new oxytocic drug (Yard) CT–202
—— Trichlorethylene, Trilene, Trimar analgesia in (Kreul) 203

PERILIMBAL SUCTION-CUP, new method for early diagnosis of glaucoma (Garner) *371
PHAGE TYPING, Don't overlook ab–128
PHARMACOLOGY, a justification (Hardman) CT–268
—— of methyldopa, an antihypertensive drug (Lum) CT–353
PLASMA PROTEINS and the gastrointestinal tract ab–355

Page

POISONING due to alkylphosphate cholinesterase inhibitors, Treatment of (Way) CT–157
—— due to cyanide, Treatment of (Way) CT–378
—— Lead 12–11
POLIOMYELITIS, Nonpolioviruses and paralytic disease ab–256
POSTHERPETIC NEURALGIA ab–370, 12–12
PREGNANCY, Secondary abdominal (Gutglass and Atamdede) *337
—— Appendicitis and ab–210
PSYCHIATRY, Expectations—great and otherwise (Aldrich) *114

RABIES in Wisconsin (Evans) *329
RADIATION, Report on iodine 131 in milk 242
RADIOISOTOPES for organ scanning, Clinical use of (Meade and Franklin) *365
RECTOSIGMOID, Adenoma of (Kalfayan) CPC–129
RENACIDIN for urinary tract irrigation, Warning re 325
RICKETS (Kasch) CPC 383
ROENTGEN DIAGNOSIS of compartmental disease of gallbladder (Nevin, Bump and Schiek, Jr.) *125
RUPTURE of esophagus, Spontaneous (Lynn) *191

SALMONELLA in shell 404
SALMONELLOSIS ab–158
SARCOIDOSIS: Hutchinson–Boeck granulomatosis; Heart in (Middleton) *109
SCIRRHOUS ADENOCARCINOMA of breast, Coexistent cystosarcoma phyllodes and (Richards and Way) *425
SMALLPOX VACCINATION in hospitals (Preizler) SBH–379
SMOKING: See under Medicolegal/Socioeconomic/Ancillary heading
SPARTEINE, new oxytocic drug (Yard) CT–202
SPERMATIC CORD, Primary fibroleiomyosarcoma of (Wagner and Teresi) *342
SUBCLAVIAN STEAL, Roentgen riddle series (Price) *504

TETANUS immunization clinics, Green County's adult SBH–403
—— infection (Brown) *400
TOCOSAMINE: See Sparteine
TRACHEO-ESOPHAGEAL FISTULA, Secondary surgery of congenital esophageal atresia with (Stoll) *416
TRAUMA, Farm accidents occurring in children (Lucas and Wirka) *405
—— Levels of consciousness in acute head injuries (Salibi) *375
TRICHLORETHYLENE: See Trilene
TRICHINOSIS, continuing public health problem ab–113
TRILENE, Trichlorethylene, Trimar analgesia in obstetrics (Kreul) 203
TRYPSIN, Anaphylactic reaction to (Liebenow) *347
TUBERCULOSIS, Oral hypoglycemic agents in diabetic patients with pulmonary ab–138
TULAREMIA in Wisconsin 118
TUMOR, Malignant mesodermal mixed (Simon) CPC–223
—— Primary fibroleiomyosarcoma of spermatic cord (Wagner and Teresi) *342
—— Wilms', study of 29 cases (Hinke and Vermund) *119

VACCINIA VIRUS, Chemotherapy of herpes simplex virus and (Hardman) CT–417
VASCULAR ACCIDENT following neck manipulation, Brain stem (Pribek) *141
VASCULAR RING anomalies (Griese and Lawton) *145

WILMS' TUMOR, Study of 29 cases (Hinke and Vermund) *119
WOUND ABSCESS (Kleppe) CPC–507
WOUND INFECTION and its prevention by topical and parenteral techniques, Experimental (Gingrass, Close and Ellison) *501

Page

ABORTION, Protect yourself ---- 26
ABORTIFACIENTS, Sale of contraceptives and 25
ADOPTIONS, Refer child placement cases to these agencies ---- 86
ADVERTISING, Index to 1962 Journal advertisers ---- 1–56*
—— Principles of, Wisconsin Medical Journal -- 1–57*
AGED care isn't true, Chief argument for (reprint) ---- 206
ALCOHOLISM in Wisconsin, 1959–1961 (Nashold and Wadsack) ---- SBH–219
AMERICAN MEDICAL POLITICAL ACTION COMMITTEE, Off the floor for '64 ---- E–161
AMERICAN MEDICAL WRITERS' ASSOCIATION, What is ---- 494
ATHLETICS, MD calls for teamwork to prevent sports injuries ---- 566
—— Physicians evaluate Little League baseball 273
AUTOMOBILE ACCIDENTS, Medicolegal responsibility in prevention of (Heise) ---- 243

BASEBALL, Physicians evaluate Little League 273
BASIC SCIENCE Law ---- 15
—— List of examiners ---- 91
BICILLIN prophylaxis program ---- 512
BIRTHS, File certificate for ---- 54
BLINDNESS, Law requires silver nitrate to prevent infant ---- 26
BLOOD TESTS, Blood grouping test for identification ---- 35
BOARD OF HEALTH, List of officers ---- 90
BOARD OF MEDICAL EXAMINERS, List of officers ---- 91
BOARD OF NURSING, List of officers ---- 93
BOARD OF PHARMACY, List of officers ---- 93
BOARD OF PUBLIC WELFARE, List of officers ---- 91
BOARD OF VOCATIONAL AND ADULT EDUCATION, List of officers ---- 92
BOOKLETS: See Pamphlets

CANCER cases, Report to State Board of Health ---- 54
CHAPTER 301, Inspection of physician and hospital records; interpretation of ---- 3
CHARTER LAW of medical societies in Wisconsin ---- 56
CHILD PLACEMENT agencies ---- 86
CHIROPODY: See Podiatry
CHIROPRACTIC, Brain stem vascular accident following neck manipulation (Pribek) -- *141
—— Deluxe ---- E–235
—— Limitations on practice ---- 24
CIGARETTE SMOKING, Pennsylvania Medical Society acts ---- 228
—— Royal College of Physicians reports on ---- 228
—— Spare the young ---- E–394
—— Wisconsin physicians and (Samp) ---- 229
CIVIL DEFENSE, Physicians staff emergency hospitals; others needed ---- MF–101
CLERGY, Confreres of the cloth ---- E–139
COMMITMENT proceedings, Registration for reference work on ---- 54
COMMUNICABLE DISEASES, Report to State Board of Health ---- 54
CONGRESS, Names and addresses of Wisconsin representatives ---- MF–107
CONTRACEPTIVES and abortifacients, Sale of ---- 25
COUNTY MEDICAL SOCIETIES, Sponsorship of health programs ---- 8
—— See also: State Medical Society/Organizational
CROW, New acting dean of UW medical school, Prof. James ---- MF–103
CUNNINGHAM, Wilson, first memorial lecture 525

DEATH CERTIFICATE, How to complete ---- 42
DETERGENTS in Wisconsin surface waters -- 315
DRUGS subject to federal narcotic laws ---- 43
DRUG SAFETY cannot be legislated (reprint) 494
DUER presents x-ray tubes to CES Foundation, Dr. ---- 12–45

Page

EDUCATION for high school youth, Family-life (Brown) ---- SBH–143
EMERGENCIES, What are your rights in ---- 12
EPILEPTICS, Drivers' licenses for ---- 10
—— Responsibility of physician conducting pre-employment examinations ---- 52
EXAMINATIONS, Post mortem ---- 52
—— Responsibility of physician conducting pre-employment ---- 52
EXTERNS: See Preceptees

FAMILY-LIFE education for high school youth (Brown) ---- SBH–143
FILMS, Obesity: Some Highlights of Management ---- 364
—— Clinical Entities ---- 258
—— Cine Coronary Arteriography ---- 251
—— Medicolegal ---- 95
—— Role of Urine in Diagnosis ---- 242
—— Ulcerative colitis ---- 12–12
FOREIGN-TRAINED physicians, Licensing of 19
FOUNDATION: See State Medical Society/Organizational

GENERAL PRACTITIONER, The satisfactions of being a (reprint) ---- 194
GERIATRICS SOCIETY sponsors essay contest 107
GUIDES, Available through SMS ----430, 559
—— Interpretation of Chapter 301 ---- 3
—— Interpretation of Medical Practice Act ---- 13
—— Physicians' guidelines for delegation of duties and functions to nurses ---- 11
—— Tax ---- 93
—— University Hospitals guide for referring physicians ---- 29

HEALTH CENTER facility, Want government to consider Wisconsin for site of new --- 419
HEALTH INSURANCE, Federal deductibility of certain ---- 47
HEALTH PROGRAMS, County medical society sponsorship of ---- 8
HEALTH SERVICE, Hospital employee (Wardlaw and Chambers) ---- SBH–190
HEART FUND leaders named ---- MF–107
HISTORY, the first fifty years—Marquette University School of Medicine (Zeit) ---- 295
HOSPITAL EMPLOYEE health service (Wardlaw and Chambers) ---- SBH–190
HOSPITAL RECORDS retention and inspection, Physician and; an interpretation of Chapter 301, Laws of 1959 ---- 3
HOSPITAL RELATIONS, medical education (Egan) ---- PP–442

ILLEGITIMACY, Blood grouping test to determine identification ---- 35
INDUSTRIAL COMMISSION, List of officers -- 92
INSURANCE, First conference on extension of voluntary health ---- 560
—— In the national spotlight ---- E–516
—— Pandemic predicament ---- E–160
—— Problems of physician's widow ---- 36
—— Professional liability, prevention and ---- 48
INTERNS, Legal status of ---- 20
ITINERANTS, Legal status of ---- 21
IVY, Dr. Andrew C., Remember the Good ---- E–445

JURY DUTY, Physicians exempt from ---- 36

KENNEDY, John F., In memoriam ---- E–515
KERR–MILLS administration, State Medical Society forms group to assist in ---- 424
—— Challenge ---- E–444
—— Governor's Commission on Aging expresses support ---- MF–107
KREBIOZEN, Remember the good ---- E–445

LAWS OF WISCONSIN, Legal limitations on treating the sick in Wisconsin; interpretation of The Medical Practice Act ---- 13
—— Medical staff rules and regulations as to sterilizations ---- 9
—— Physician and hospital records retention and inspection; interpretation of Chapter 301 ---- 3

Page

— Right to use title "doctor" in Wisconsin -- 27
LEGISLATURE, Assembly members, names and addresses ---------- MF-104
— State Senate, names and addresses ------ MF-106
LICENSE, Can you practice without a ------ 35
— Drivers' licenses for epileptics ---------- 10
— Legal status of doctor without a -------- 35
— Licensing of foreign-trained physicians -- 19
— Revocation or suspension of ---------- 21
— Temporary ---------- 19
LICENSURE of physicians ---------- 16
LITERATURE: See Pamphlets
LOANS available to medical students -------- 37
LOCUM TENENS ---------- 50

MALPRACTICE, Problems of physician's widow ---------- 36
— Professional liability, prevention and insurance ---------- 48
MARCH OF MEDICINE, Schedule of programs 96
MARQUETTE UNIVERSITY School of Medicine, First fifty years (Zeit) ---------- 295
— Half century of service (Hirschboeck) ---- 293
— Salute to 50 years of progress (Annis) -- 294
MASSAGE and hydrotherapy, Limitations on practice ---------- 22
MATERNITY HOMES, Licensed---------- 86
MEDICAL ASSISTANT courses in state by September, Four approved ---------- 201
MEDICAL ECONOMICS, What are laboratory tests costing your patient? ---------- 194
— Pandemic predicament ---------- E-160
MEDICAL EDUCATION, Hospital relations (Egan) ---------- PP-442
MEDICAL ETHICS of the American Medical Association, Principles of ---------- 65
MEDICAL FORUM ---------- 101
MEDICAL STUDENTS essay contest sponsored by ACCP ---------- MF-108
— Loans and scholarships available to Wisconsin ---------- 37
— trained in far off Madagascar and South Vietnam ---------- 8-40
MEDICAL PRACTICE ACT, Enforcement of -- 24
— Legal limitations on treating the sick in Wisconsin; an interpretation of -------- 13
MEDICAL RECORDS, How long should you keep case records and x-rays ---------- 55
— Physician and hospital records retention and inspection; an interpretation of Chapter 301, Laws of 1959 ---------- 3
— Problems of physician's widow ---------- 36
MEDICAL SOCIETY participation, Sincerely yours (Hill) ---------- PP-159
— Value of quality (Hill) ---------- PP-204
MEDICARE benefits extended to dependents of NATO forces ---------- 5-36
MEDICINE AND SURGERY, Licensing requirements and procedures ---------- 16
MEDICOLEGAL information, films, speakers, literature available ---------- 95
— responsibility in prevention of automobile accidents (Heise) ---------- 243
— University of Wisconsin correspondence instruction program "Legal Problems in Practice of Medicine" ---------- 419
MENTAL HEALTH hearings scheduled in 22 Wisconsin cities ---------- 10-46
— some county hospitals to be used for local rehabilitation ---------- MF-108
— Voluntary admission of mentally retarded children under three years of age ------ 12-11

NARCOTICS, Annual registration ---------- 54
— drug losses, Reporting of ---------- 5-36
— How long should you keep prescriptions -- 55
— laws, Drugs subject to federal ---------- 43
— Preprinted prescription blanks ---------- 10
NURSES, Physicians' guidelines for delegation of duties and functions to ---------- 11
— Propose specialized training of OB ------ MF-103
— Public health; family centered service (Rowley) ---------- SBH-511

Page

OPTOMETRY, Limitations on practice -------- 24
ORTHOPEDIC FIELD CLINICS, Schedule of-- 1-38, 348
OSTEOPATHY, Requirements and procedures to practice ---------- 23

PAMPHLETS, Childhood leukemia ---------- 251, 435
— Dental care before the baby is born ------ 494
— FACOG ---------- 494
— Handicapped children ---------- 503
— Health careers guide ---------- 248
— Let these guides help you ---------- 377, 430
— Medicolegal ---------- 95
— Occupational health bookshelf ---------- 443
PATERNITY, Blood grouping test for identification ---------- 35
PHARMACIST, The associated professions (Hill) ---------- PP-137
PSYCHOLOGISTS, Licensure of ---------- E-234
PHYSICAL THERAPY, Limitations on practice 22
PHYSICIAN RESPONSIBILITY, Can you practice without a license? ---------- 35
— Family life education for high school youth SBH-143
— Guidelines for delegation of duties and functions to nurses ---------- 11
— How to complete a death certificate ------- 42
— How long should you keep your professional case records and x-rays? -------- 55
— Legal limitations on treating the sick in Wisconsin, interpretation of the Medical Practice Act ---------- 13
— Locum tenens ---------- 50
— Medical staff rules and regulations as to sterilizations ---------- 9
— of physician conducting pre-employment examinations ---------- 52
— Physicians exempt from jury duty ------- 36
— Post mortem examination ---------- 52
— Problems of physician's widow ---------- 36
— We can, in 1964, avoid the royal road to ruin (Egan) ---------- PP-513
— What are your rights in emergencies? ---- 12
— Your deadlines and other "musts" -------- 53
PODIATRY, Requirements to practice ------- 23
POISON INFORMATION CENTERS, List of -- 51
POLITICS, Off the floor for '64 ---------- E-161
POWELL, Joseph, receives "Golden Apple" award ---------- MF-103
PRACTICE OF MEDICINE, Satisfactions of being a general practitioner ---------- 194
— Serious shortage ---------- E-205
— Value of quality (Hill) ---------- PP-204
PRECEPTEES, Legal status of ---------- 20
PRE-EMPLOYMENT EXAMINATIONS, Responsibility of physician conducting ---- 52
PRESCRIPTION blanks, Preprinted ---------- 10
PREVENTATIVE MEDICINE (reprint) ----- 273
PROJECT HOPE needs help ---------- 6-8
PUBLIC RELATIONS, Eulogy to a small town country doctor (Murphy) ---------- 446
— Good way to improve (reprint) ---------- 447

RADIO, "Citizens band" national group forms MF-103
RECORDS and x-rays?, How long should you keep your professional case ---------- 55
— Problems of physician's widow ---------- 36
— Retention and inspection of physician and hospital ---------- 3
REGISTRATION, Annual narcotics ---------- 54
— for commitment procedures ---------- 54
— in Wisconsin, Annual ---------- 54
RESIDENTS, Legal status of ---------- 20

SATELLITE, Fetal heartbeats transmitted to Paris via relay ---------- 8-39
SCHOLARSHIPS and medical loans available to Wisconsin medical students ---------- 37
SEAT BELTS ---------- 12-11
SHRINE BURN CENTER for children (Hill)-- PP-97
SMALLPOX immunization, AMA campaign for continuing ---------- MF-108
— vaccination, Surgeon General recommendation on ---------- 441
SMOKING: See Cigarette Smoking
SPEAKERS, Medicolegal ---------- 95
STATE OFFICERS and their addresses ------- MF-102
STERILIZATIONS, Medical staff rules and regulations ---------- 9

Page

TAXES, Do you employ four or more persons? 8
— Federal deductibility of certain health and accident insurance 47
— Federal income tax notes for 1962 41
— Tax guide available 93
— Your deadlines and other "musts" 53
THORNTON, Dr. John, Eulogy to a small town country doctor (Murphy) 446

UNIVERSITY HOSPITALS, Guide for referring physicians 29
— Research project uses students and families 428
— Speech and hearing clinic 450

WIDOW, Problems of a physician's 36
WISCONSIN HEALTH SERVICE, Kerr-Mills challenge E-444
— SMS forms group to assist in Kerr-Mills administration 424

X-RAYS, How long should you keep your case records and 55

STATE MEDICAL SOCIETY/ORGANIZATIONAL

Page

ACTIVITIES at SMS headquarters 4-62
ANNUAL MEETING, 1963 program 1-16*, 2-6, 163, 4-41
— 1964, Official call for scientific exhibits 10-24, 12-27

BOOKSHELF, Book reviews 9-55, 10-60
— Basic Anxiety 10-60
— Cardiac Arrhythmias 9-58
— Congenital Malformations 9-56
— Dermatology, Practical Pediatric 10-61
— Epidemic 10-60
— Health Education 9-55
— Heredity in Ophthalmology 9-57
— Human Frame 10-60
— Hypertension, Essential 9-58
— Otolaryngology, Textbook of 9-56
— Pathology 9-57
— Progesterone and the Defense Mechanism of Pregnancy 9-56
— Radiation Dosimetry, Principles of 9-58
— Shock Pathogenesis and Therapy 10-61
— Smoking and Health 9-55
— Steric Course of Microbiological Reactions 10-60
— Surgery, Problems in 9-57
— Traitor Within: Our Suicide Problem 10-60

CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION, List of officers and board of trustees 94
— Dr. Duer presents x-ray tubes to 12-45
— Parsimony in dairyland E-100
— Sculpture of staff of Aesculapius presented to 140
— Wilson Cunningham day, first memorial lecture 525
CHARTER LAW of medical societies in Wisconsin 56
CONSTITUTION and bylaws 57
— Amendments to 3-54, 4-70
CORRESPONDENCE: See Letters
COUNCIL AWARD, Recipients of 86
COUNCIL COMMITTEES 83, 84, 85
COUNCIL MEETINGS, Minutes of
— Minneapolis, Minn., Nov. 9-10, 1962 239
— Madison, Feb. 23-24, 1963 274
— Madison, Apr. 6, 1963 (special session) 280
— Milwaukee, May 5, 1963 361
— Madison, July 27-28, 1963 517
COUNCILOR DISTRICTS 80
COUNTY MEDICAL SOCIETIES, List of officers and scheduled meetings 88, 4-74, 5-54, 291, 10-65
— proceedings 2-39, 4-55, 8-23, 10-31, 11-31, 12-29
Brown 2-39, 4-55, 8-23, 10-33
Chippewa 2-39
Crawford 10-31
Dane 2-39, 4-55, 8-23, 10-31, 11-31, 12-29
Dodge 2-39, 4-55
Douglas 2-39, 4-55, 10-31
Eau Claire-Dunn-Pepin 2-39
Grant 2-39
Green 2-40
Green Lake-Waushara 2-40
Jefferson 2-40
Kenosha 2-40, 4-55
La Crosse 2-40, 4-55, 8-23, 10-31
Langlade 4-56
Marathon 2-40, 8-23
Milwaukee 2-40
Oconto 4-56
Oneida-Vilas 4-56
Outagamie 2-41, 4-56
Ozaukee 2-41, 4-56, 12-29
Pierce-St. Croix 4-56, 8-23, 10-31, 11-31, 12-29
Portage 2-41
Price-Taylor 8-23
Racine 2-41, 4-56, 8-23, 10-31, 11-31, 12-29
Richland 2-42, 4-56, 8-23, 11-31
Rock 10-31
Sauk 4-56, 8-23, 10-33, 11-31
Trempealeau-Jackson-Buffalo 2-42, 4-56, 8-25, 10-33, 11-31, 12-29
Waupaca 2-42
Winnebago 11-31
Wood 2-42, 4-56, 11-31
— sponsorship of health programs 8

EDITORIALS 98, 139, 160, 205, 234, 271, 327, 358, 393, 422, 444, 515
— A remedy 327
— A strong ally 423
— Better way 234
— Calling all counties; guest editorial 359
— Confreres of the cloth 139
— Cytologic revolution 235
— Deluxe chiropractic 235
— Distaff dialectics 272
— Down the drain 393
— Earl R. Thayer: friend of medicine 360
— Fair trade time again 422
— In memoriam: J. F. K. 515
— In the national spotlight 516
— Kerr-Mills challenge 444
— Off the floor for '64 161
— Our sixtieth 98
— Pandemic predicament 160
— Parsimony in dairyland 100
— Remember the good 445
— Serious shortage 205
— Somehow labor speaks 271
— Spare the young 394
— The national anguish 358
EGAN, William J. M. D., New president (biography and picture) 233

HEALTH FADS AND FALLACIES conference, Invitation 162
— Picture round-up, your Society in action 236
HOUSE OF DELEGATES, attendance at regular session 492
— Attendance at interim session 557
— President's message to (Egan) 241
— Summary report of interim session 448
— Summary report of regular session 283
— Reports presented at 1963 interim session, Oct. 18-19, Madison 527
— Transactions of 1963 interim session, Oct. 18-19, Madison 541
— Transactions of 1963 regular session, May 6-7-8, Milwaukee 451

LETTERS 4-7, 5-6, 6-7, 7-6, 9-7, 12-11
LICENTIATES, Recent Wisconsin 2-50

MEDICAL ART SALON, Woman's auxiliary annual meeting feature 1-18*, 2-10, 290
MEDICAL MEETINGS, Postgraduate courses 1-37*, 2-57, 3-45, 4-69, 5-49, 6-37, 7-35, 8-53, 9-43, 10-51, 11-53, 12-59
MEMBERS, List of SMS 67

Page

NEWS OF WISCONSIN PHYSICIANS ..2–45, 4–59, 5–21, 6–25, 7–27, 8–31, 9–27, 10–41, 11–39, 12–37

OBITUARIES, Deceased physicians 3–35, 4–65, 5–25, 8–41, 9–37, 12–51

— Aageson, Herman A., Oconto 8–43
— Adrians, Wilbert A., Appleton 12–51
— Aktekin, Hikmet, Superior 4–65
— Andre, Edgar F., Kenosha 8–41

— Bassuener, Reynold O., Milwaukee 3–38
— Biljan, Matthew W., West Allis 3–36
— Blekking, John H., Sunny Ridge 5–28
— Bodden, Alphonse M., Milwaukee 9–37
— Briggs, Merlin, C., Milwaukee 8–42

— Cairns, Rolla U., River Falls 8–41
— Cole, David F., Ripon 3–36
— Coon, Harold M., Milwaukee 3–35
— Cox, John A., Milwaukee 8–41
— Curtin, Donald W., Kimberly 8–42

— Daley, David M., La Crosse 12–52
— Dallwig, Eugene L., Milwaukee 8–42
— Davis, Adrian W., Madison 5–25
— Droege, C. T., Superior 12–52
— Dushack, William H., Sun Prairie 3–35

— Eberbach, Carl W., Milwaukee 4–65

— Froede, Herbert E., Silver Spring, Md. 3–38

— Gauger, Adeline, Wadsworth, Kan. 5–28
— Grossman, Max A., Green Bay 3–35
— Guerin, Leon H., Milwaukee 3–39
— Guzzetta, Vincent J., Milwaukee 12–52

— Hake, Cecil B., Milwaukee 3–38
— Harman, John C., La Crosse 12–52
— Haubrick, Hubert J., Oshkosh 3–35
— Heidner, Albion A., West Bend 5–25

— Irwin, Robert S., Milwaukee 9–37

— Jacobson, Edward B., Milwaukee 3–39
— Jane, William F., Chippewa Falls 5–25
— Jarvis, Edward C., Tomahawk 12–51
— Johnson, Willis L., Janesville 3–36

— Kazmierowski, John J., Milwaukee 8–42
— Kelley, Francis H., Merrill 3–38
— Kelly, Joseph A., Chippewa Falls 8–42
— Kispert, Robert W., Green Bay 12–51
— Klein, John T., Milwaukee 9–37
— Knauf, Arthur J., Sheboygan 9–37
— Knudsen, Else, Iola 3–35

— Lautenbach, Edward T., Waupun 3–38
— Loughnan, Andrew J., Oconomowoc 5–26
— Lund, Simon O., Cumberland 5–26

— MacLaren, John B., Milwaukee 9–37
— Mailer, Andrew R., Madison 4–65
— Marsh, Hector C., Shawano 12–51
— Maxwell, Harry P., Milwaukee 12–52
— Mayfield, Alfred L., Kenosha 12–54
— McGuire, William H., Janesville 5–26
— Medley, Seth R., Spooner 3–36
— Meek, Walter J. (Ph.D.), Ft. Myers Beach, Fla. 8–41
— Merrill, W. G., Ashland 5–25
— Morgan, Lillie M., Long Beach, Calif. 5–26
— Morrison, John T., Bethesda, Md. 5–28

— Peterson, Enoch F., Wauwatosa 9–38
— Proctor, Thomas C., Egg Harbor 9–37

— Raymond, Rolland G., Brownsville 3–39
— Reay, G. R., Onalaska 12–54
— Rheineck, Arthur F., Oconomowoc 5–28
— Robbins, James M., Milwaukee 5–26
— Rogers, Malcolm F., Milwaukee 5–25
— Rumph, Charles L., Milwaukee 5–25
— Russell, Sidney B., Eau Claire 8–41

— Sabin, Richard P., Madison 5–28
— Schroeder, Claude F., Milwaukee 8–43
— Schubert, Clarence K., Madison 12–51
— Schwarz, Samuel G., Black River Falls 3–35
— Senn, Ulrich, Milwaukee 12–51
— Sharpe, Jeremy J., Fond du Lac 8–43
— Steele, George A., Oshkosh 8–41

Page

— Strauch, Clauss B., Hazel Green 4–65
— Sydow, William O., Wauwatosa 9–38

— Taylor, Robert D., Marshfield 4–65
— Tessier, Alban, Milwaukee 5–26
— Tolan, Thomas L., Milwaukee 3–39
— Trautmann, Milton, Prairie du Sac 12–54
— Truitt, John W., Fort Lauderdale, Fla. 3–38
— Turney, Cyril F., Milwaukee 8–42

— Ulrich, Charles F., Kenosha 3–38

— Venning, John R., Fort Atkinson 3–36
— Vivian, Robert S., Beloit 12–52

— Waldeck, Edward A., Milwaukee 9–38
— Weeks, Frank D., Ashland 3–36
— Welch, Fred B., Janesville 3–39
— Whalen, George E., Milwaukee 3–35
— Wheeler, William P., Oshkosh 5–28
— Wiley, Ralph H., Iola 3–36

— Zurheide, Harry J., Elm Grove 3–39

OFFICERS AND COUNCILORS, List of for 1962–1963 81

OFFICERS OF SECTIONS, List of 84

PAST PRESIDENTS, List of 87

PHYSICIANS' EXCHANGE 1–58*, 2–65, 3–55, 4–71, 5–51, 6–43, 7–43, 8–61, 9–65, 10–67, 11–59, 12–63

PLACEMENT SERVICE aids doctors and communities 64

PRESIDENTIAL CITATION, Recipients of 86

PRESIDENTS' PAGE 97, 137, 159, 204, 233, 326, 356, 390, 420, 442, 513
— Associated professions (Hill) 137
— Hospital relations . . . medical education (Egan) 442
— Is the Wisconsin State Medical Society the "conscience of medicine" in our state? (Egan) 420
— New president (Egan) 233
— Shrine Burn Center for Children (Hill) 97
— Significant meetings (Egan) 326
— Sincerely yours (Hill) 159
— Trio becomes a quartet (Egan) 356
— Value of quality (Hill) 204
— We can, in 1964, avoid the royal road to ruin (Egan) 513
— We can learn from others (Egan) 390

SERVICES TO MEMBERS 66

SOCIETY RECORDS 1–35*, 5–33, 6–31, 8–45, 11–49

SPECIALTY SOCIETY proceedings 2–43, 4–47, 8–27, 10–35, 11–33, 12–31
— American Association of Medical Assistants 12–31
— American Cancer Society, Kenosha County Unit 2–43
— American Cancer Society—Wisconsin Division 10–36, 12–31
— American College of Obstetricians and Gynecologists 11–33
— American Physicians & Surgeons, Wisconsin Chapter 8–27
— Milwaukee Academy of Medicine 4–57
— Milwaukee Academy of Surgery 11–33
— Milwaukee Oto-Ophthalmic Society 4–57, 2–43, 10–35, 12–31
— Northern Wisconsin Dietetic Association 11–35
— Wisconsin Academy of General Practice 10–35
— Wisconsin Academy of General Practice, Madison Chapter 4–57
— Wisconsin Allergy Society 12–31
— Wisconsin Association of MTS 11–33
— Wisconsin Association of Psychiatric Clinics for Children 12–31
— Wisconsin Psychiatric Association 4–57, 2–43, 11–35, 12–31
— Wisconsin Public Health Association 8–29
— Wisconsin Radiological Society 11–35
— Wisconsin Society of Anesthesiologists 10–35
— Wisconsin Society of Internal Medicine 12–34
— Wisconsin Society of Obstetrics and Gynecology 10–35
— Wisconsin Society of Pathologists 11–33
— Wisconsin Society of Plastic Surgeons 12–31
— Wisconsin State Medical Assistants Society 8–27, 10–35

State Medical Society/Organizational—continued

Page

— Wisconsin State Medical Golf Association 11–33
— Wisconsin Surgical Society 8–27, 10–35
— Wisconsin Urological Society 10–35
STANDING COMMITTEES, List of, for 1962–1963 82

TERRITORIAL LEGISLATION, Creating 56
WISCONSIN HEALTH SERVICE, Kerr–Mills challenge E–444
— SMS forms group to assist in Kerr–Mills administration 424
WISCONSIN MEDICAL JOURNAL, List of editorial staff, editorial board, and commission on scientific medicine 2

Page

— Our sixtieth E–98
— Preparation of manuscripts for 1–6*, 382
— Principles of advertising 1–57*
— Index to 1962 advertisers 1–56*
WISCONSIN PHYSICIANS SERVICE, Facts about 1–46*, 2–34, 3–52, 4–68, 5–35, 6–30, 7–33, 8–12, 9–54, 10–62, 11–40, 12–50
— First conference on extension of voluntary health insurance 560
— income and reserves increase MF–108
— In the national spotlight E–516
WISCONSIN WORK WEEK OF HEALTH planned MF–101, 4–62
WOMAN'S AUXILIARY, Medical art salon 1–18*, 2–10, 4–52, 290

INDEX TO ADVERTISERS

Ames Company, Inc. 75

Barr X-ray Co. 57
Beecher's—TV & Stereo 4
Borden's 46
Burroughs Wellcome & Co., Inc. 55

Chatham Pharmaceuticals, Inc. 13
Chicago Medical Society 62
Coca Cola Co. 62

Davies, Rose & Company, Ltd. 36

Endo Laboratories 6

Geigy Pharmaceuticals 7, 8, 9, 10

Haug Drug Company 36, 56
Hotel Schroeder 4
House of Bidwell, Inc. 57
Hurley X-ray Company 46

Johnson & Johnson 24, 25

Keeley Institute, The 36

Lilly and Company, Eli front cover, 18
Lederle Laboratories 14, 48, 49

Medical Protective Company, The 30
Milwaukee Sanitarium Foundation 46

New Orleans Graduate Medical Assembly 60

Parke, Davis & Company 2, 3
Physicians' Exchange 63, 64, 65

Rennebohm's 46
Roche Laboratories back cover
Rogers Memorial Hospital 30
Rorer, Inc., William H. 26

Sacred Heart Sanitarium 38
St. Croixdale Sanitarium 4
St. Mary's Hill Hospital 54
Sanborn Company 21
Saunders Company, W. B. 15
Schering Corp. 17
Searle & Co., G. D. 19
Shorewood Sanitarium 57
Smith Kline & French Laboratories 58
Spence–McCord 12

Time Insurance Company 57

Wallace Laboratories 13, 16, 22, 23, 32, 33, 35
Winthrop Laboratories 20, 42, 53
Wisconsin Physicians Service 50

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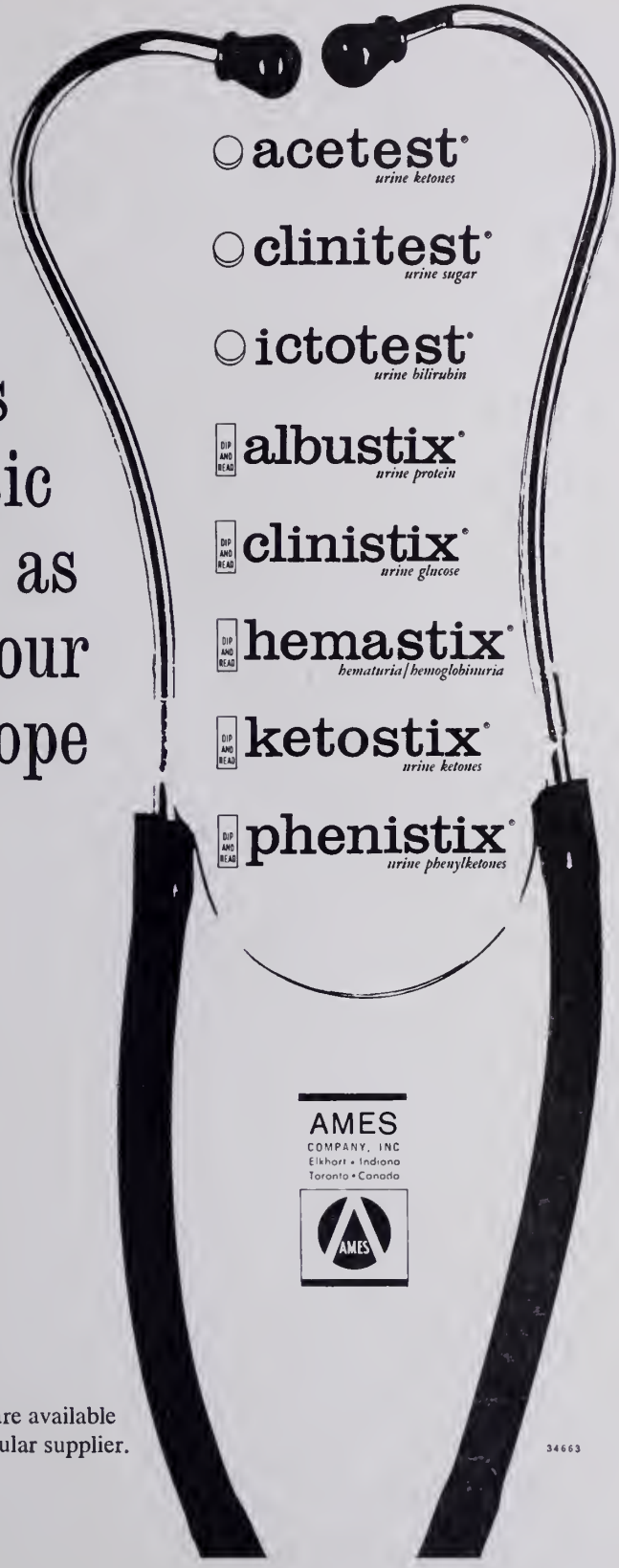

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